

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doctor is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the coroner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8105

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08086

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN lb 5 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING BROOK HIGH SCHOOL			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Pr. Geo's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE d. STREET ADDRESS R.F.D. #1, Box 210 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ARNE First Middle Last 4. DATE OF DEATH JULY 25 Month Day Year 19 60			5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10/3/95 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employd Carpenter 10b. KIND OF BUSINESS OR INDUSTRY Gen. Contracting 11. BIRTHPLACE (State or foreign country) NORWAY 12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Unknown AARO Thomas 14. MOTHER'S MAIDEN NAME RAGNILD UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) -- 16. SOCIAL SECURITY NO. 052-07-1654 17. INFORMANT Mrs. Dorothy E. Aaro, R.F.D.#1, Box 210 Address Brandywine, Maryland			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 min.		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type) JOHN G. BALL			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 25 July 1960.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/60		22c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery	
22d. LOCATION (City, town, or county) Horsehead		(State) Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home ADDRESS Upper Marlboro, Md.			24a. REC'D BY REGISTRAR JUL 29 '60 DATE		

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8106

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08087

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2008 Glen Ross Road</u>				d. STREET ADDRESS <u>2008 Glen Ross Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Martin</u> Last <u>Abel</u>				4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 16, 1920</u>	
9. AGE (In years lost birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min.		IF UNDER 24 HRS. Hours <u>14</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Budget Analyst</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt - U.S. Dept. of Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Frank J. Abel</u>				14. MOTHER'S MAIDEN NAME <u>Cora Deitrich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>WW 2</u>		17. INFORMANT <u>Mrs. Jeanne T. Abel, 2008 Glen Ross Rd., S.S., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma of Spleen ± Metastases</u> DUE TO (b) <u>199.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>199.1</u> DUE TO (c) <u>199.1</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1959</u> to <u>July 1960</u> that (I) (we) last saw the deceased alive on <u>7/13</u> 19 <u>60</u> and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Maurice Franks</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/14/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Maurice Franks</u>				22d. ADDRESS <u>901 20th NW, Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July 18, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Humphrey, Inc., Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE JUL 19 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

8108

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may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove garbage papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8187

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08088

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New York b. COUNTY Troy			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 7 Thompson			
3. NAME OF DECEASED (Type or print) First Robert Middle John Last AKIN				4. DATE OF DEATH Month July Day 3 Year 1960			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 23 1925	9. AGE (In years lost birthday) 35 yrs.	IF UNDER 1 YEAR Months 35 Days 3 Hours 3 Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Joseph AKIN				14. MOTHER'S MAIDEN NAME Cathrine Malanify			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 3-20-43 081 32 6424		17. INFORMANT Mrs. Cathrine AKIN (2 above)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 201X (c) 4 mo.						INTERVAL BETWEEN ONSET AND DEATH 4 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Troy	(County) New York		(State)	
21. I certify that (I) (this hospital) attended the deceased from June 24 19 60 to July 2 19 60 , that (I) (we) last saw the deceased alive on 2 July 19 60 , and that death occurred at 0903 A.M. from the causes and on the date stated above.							
22a. SIGNATURE John Wood Davis				22b. DATE SIGNED June 24 1960		22c. PHYSICIAN'S NAME (Type) JOHN WOOD DAVIS LT MC USN	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 7-6-60		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Troy New York	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest Q. Adams				25a. REC'D BY REGISTRAR JUL 6 '60		25b. REGISTRAR'S SIGNATURE Charles E. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8188

CERTIFICATE OF DEATH

Reg. Dist. No.

08089

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 4550 Conn. Ave. NW.	
3. NAME OF DECEASED (Type or print) First Olivia D.C. Middle Andersen Last Andersen		4. DATE OF DEATH Month July Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/84
9. AGE (In years lost birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Housekeeper	
11. BIRTHPLACE (State or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dr. Dexter Bullard- Rockville, Md.		500 W. Montg. Ave. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction, left DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ethanolism, left middle cerebral artery DUE TO 2 Days (c) Myocardial Infarction with mural thrombus, left apex DUE TO 8 Days		INTERVAL BETWEEN ONSET AND DEATH 2 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 60 , to July 9 , 19 60 , that I last saw the deceased alive on July 8 , 19 60 , and that death occurred at 9:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Corinne Cooper		ADDRESS (Street, city or town, state) 104 S Washington St. Rockville Maryland.	
PHYSICIAN'S NAME (Type) CORINNE COOPER		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/60	
22c. NAME OF CEMETERY OR CREMATORY Rockville		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler, Rockville, Md		24a. REC'D BY REGISTRAR DATE JUL 12 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Hines			

11882

CERTIFICATE OF DEATH

1188

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		Jan 15, 1912		New York City	
Cause of Death		Duration of Illness		Occupation		Marital Status		Signature of Physician		Signature of Registrar	
Heart Disease		3 days		Farmer		Married		[Signature]		[Signature]	
Burial Place		Funeral Home		Burial Date		Burial Time		Burial Place		Burial Time	
St. John's Church		123 Main St.		Jan 18, 1912		10:00 AM		St. John's Church		10:00 AM	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

8189

CERTIFICATE OF DEATH

Reg. Dist. No.

08090

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 5222 41st Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jean Middle M Last Bacon				4. DATE OF DEATH Month July Day 4 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 22, 1891	
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John Henry Mullings				14. MOTHER'S MAIDEN NAME Georganna Bollinger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. 579-16-6700		17. INFORMANT (Husband) Waldo Bacon	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade DUE TO Rupture left Atrial Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Massive Myocardial Infarction (b) — (c) —				INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden 12 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from June 22, 1960 to 4 July, 1960 , that I last saw the deceased alive on 4 July, 1960 , and that death occurred at 12:49 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Horace W. Bernton M.D.				ADDRESS (Street, city or town, state) 10571 Summit Ave DATE SIGNED —			
PHYSICIAN'S NAME (Type) Horace W. Bernton				22a. BURIAL, CREMATION, REMOVAL (Specify) burial			
22b. DATE THEREOF 7/7/60				22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St. N.W.		24a. REC'D BY REGISTRAR JUL 6 60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines				DATE —			

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BP

DEPARTMENT OF HEALTH
DISTRICT OF COLUMBIA

1913

Name

Age

Sex

Place of Birth

Occupation

Married

Previous Illness

U.S.

On May 1st, 1913

(Signature)

Attest: Health Officer

Health Officer

Attest: Health Officer

1913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

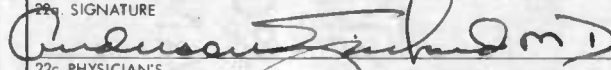
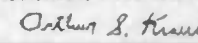
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08091

8190

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Penfield		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 7 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Penfield		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 1925 Baird Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Jack Middle Joseph Last Barbieri			4. DATE OF DEATH Month July Day 29 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1925		9. AGE (In years lost birthday) 35 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY (Unknown)	11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Louis Barbieri			14. MOTHER'S MAIDEN NAME Sabina Parchi		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II Unascertainable	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cryptococcal Meningitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkin's Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 22 19 60 to July 29 19 60 , that (I) (we) last saw the deceased alive on July 29 19 60 , and that death occurred 7:45p PM, from the causes and on the date stated above.					
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-30-60	
22c. PHYSICIAN'S NAME (Type) W. ANDERSON SPICKARD, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 7-30-60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY St. Charles Pinelawn	
				23d. LOCATION (City, town, or county) (State) Long Island, New York	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE AUG 3 '60	
				25b. REGISTRAR'S SIGNATURE 	

Burial-transit 7-30-60

St. Charles Pinelawn

Long Island, New York

ROBERT A. PUMPHREY

Bethesda, Md.

AUG 3 '60

Arthur S. Kraus

9018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08092

8191

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Bryans Road Trailer Camp			
3. NAME OF DECEASED (Type or print) First Baby Girl Middle BARNA Last BARNA				4. DATE OF DEATH Month July Day 12 Year 1960			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-12-60	
9. AGE (In years lost birthday) yrs. 2		10. AGE (In years lost birthday) yrs. 35		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY ---			
13. FATHER'S NAME Joseph G. BARNA, Sr.				14. MOTHER'S MAIDEN NAME Jacqueline OSTRANDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 7762 IMMEDIATE CAUSE (a) Immaturity (26 weeks gestation) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Arlington				20g. (County) Virginia			
21. I certify that (I) (the hospital) attended the deceased from Birth to July 12, 1960, that (I) (we) lost the deceased alive on July 12, 1960, and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE John H. Mazur				22b. DATE SIGNED 7-13-60			
22c. PHYSICIAN'S NAME (Type) J. H. MAZUR, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7-15-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town, or county) Arlington				23e. (State) Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				24a. ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR JUL 15 '60	
25b. REGISTRAR'S SIGNATURE G. L. S. Piro				25c. DATE JUL 15 '60			

Noos

2051224XV0

CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Frank J. Broschart, Dep. Med. Exam. notified and approved.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 13 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8113 Carroll Lane				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 8113 Carroll Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Edna R. Bassett				4. DATE OF DEATH Month July Day 8 Year 1960											
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 30, 1880		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY own home				11. BIRTHPLACE (State or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John L. Bentzler				14. MOTHER'S MAIDEN NAME Anna Clements											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Forest M. Bentzler, 8113 Carroll Lane, S.S. Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Coronary insufficiency DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes												INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Oct 20 1954 to July 8 1960 , that (I) (we) last saw the deceased alive on June 15 1960 and that death occurred at 1:15 M, from the causes and on the date stated above.															
22a. SIGNATURE R. Lee Spire				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED July 8 1960							
22c. PHYSICIAN'S NAME (Type) R. Lee Spire				22d. ADDRESS 7600 Connecticut Ave Wash DC											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF JULY 11, 1960		23c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY				23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.					
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC, SILVER SPRING, MD. Raymond A. Ziska						ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

8107

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS

NAME

DATE OF BIRTH

SEX

DATE OF DEATH

SILVER SPRING

11 years

MALE

1115 Carroll Lane

1115 Carroll Lane

January

11

John

June 30, 1940

He died of

Heart failure

Heart failure

Heart failure

Heart failure

None

NO

Handwritten signature

WASHINGTON, D.C.

U.S. GOVERNMENT PRINTING OFFICE

1940

U.S. GOVERNMENT PRINTING OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08094

8192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURTONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURTONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NEW ROUTE 29</u>				d. STREET ADDRESS <u>NEW ROUTE 29</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>L.</u> Last <u>BEALL</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 29, 1898</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL CROP FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>BURTONSVILLE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WM. EDWARD BEALL</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA ELLEN MERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-38-3834</u>		17. INFORMANT Address <u>MRS. HELEN GIBSON BEALL, BURTONSVILLE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCUMSCRIBED, PNEUMONIA</u> DUE TO <u>180X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
				20f. (City or town) <u>—</u>		(County) (State)	
21. I certify that I attended the deceased from <u>7/19/60</u> , 19 <u>60</u> , to <u>7/19/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/19/60</u> , 19 <u>60</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>F. L. Weaver</u> M.D.							
PHYSICIAN'S NAME (Type) <u>320 Montgomery</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 22, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BURTONSVILLE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				ADDRESS <u>254 Carroll St. N.W. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 22 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

Form No. 10

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>Johns Hopkins</u></p>	
<p>5. Date of death: <u>Jan 1, 1950</u></p>		<p>6. Place of death: <u>Johns Hopkins</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>Jan 1, 1950</u></p>		<p>12. Place of registration: <u>Johns Hopkins</u></p>	
<p>13. Name of informant: <u>John Doe</u></p>		<p>14. Address of informant: <u>Johns Hopkins</u></p>	
<p>15. Name of informant: <u>John Doe</u></p>		<p>16. Address of informant: <u>Johns Hopkins</u></p>	
<p>17. Name of informant: <u>John Doe</u></p>		<p>18. Address of informant: <u>Johns Hopkins</u></p>	
<p>19. Name of informant: <u>John Doe</u></p>		<p>20. Address of informant: <u>Johns Hopkins</u></p>	
<p>21. Name of informant: <u>John Doe</u></p>		<p>22. Address of informant: <u>Johns Hopkins</u></p>	
<p>23. Name of informant: <u>John Doe</u></p>		<p>24. Address of informant: <u>Johns Hopkins</u></p>	
<p>25. Name of informant: <u>John Doe</u></p>		<p>26. Address of informant: <u>Johns Hopkins</u></p>	
<p>27. Name of informant: <u>John Doe</u></p>		<p>28. Address of informant: <u>Johns Hopkins</u></p>	
<p>29. Name of informant: <u>John Doe</u></p>		<p>30. Address of informant: <u>Johns Hopkins</u></p>	
<p>31. Name of informant: <u>John Doe</u></p>		<p>32. Address of informant: <u>Johns Hopkins</u></p>	
<p>33. Name of informant: <u>John Doe</u></p>		<p>34. Address of informant: <u>Johns Hopkins</u></p>	
<p>35. Name of informant: <u>John Doe</u></p>		<p>36. Address of informant: <u>Johns Hopkins</u></p>	
<p>37. Name of informant: <u>John Doe</u></p>		<p>38. Address of informant: <u>Johns Hopkins</u></p>	
<p>39. Name of informant: <u>John Doe</u></p>		<p>40. Address of informant: <u>Johns Hopkins</u></p>	
<p>41. Name of informant: <u>John Doe</u></p>		<p>42. Address of informant: <u>Johns Hopkins</u></p>	
<p>43. Name of informant: <u>John Doe</u></p>		<p>44. Address of informant: <u>Johns Hopkins</u></p>	
<p>45. Name of informant: <u>John Doe</u></p>		<p>46. Address of informant: <u>Johns Hopkins</u></p>	
<p>47. Name of informant: <u>John Doe</u></p>		<p>48. Address of informant: <u>Johns Hopkins</u></p>	
<p>49. Name of informant: <u>John Doe</u></p>		<p>50. Address of informant: <u>Johns Hopkins</u></p>	
<p>51. Name of informant: <u>John Doe</u></p>		<p>52. Address of informant: <u>Johns Hopkins</u></p>	
<p>53. Name of informant: <u>John Doe</u></p>		<p>54. Address of informant: <u>Johns Hopkins</u></p>	
<p>55. Name of informant: <u>John Doe</u></p>		<p>56. Address of informant: <u>Johns Hopkins</u></p>	
<p>57. Name of informant: <u>John Doe</u></p>		<p>58. Address of informant: <u>Johns Hopkins</u></p>	
<p>59. Name of informant: <u>John Doe</u></p>		<p>60. Address of informant: <u>Johns Hopkins</u></p>	
<p>61. Name of informant: <u>John Doe</u></p>		<p>62. Address of informant: <u>Johns Hopkins</u></p>	
<p>63. Name of informant: <u>John Doe</u></p>		<p>64. Address of informant: <u>Johns Hopkins</u></p>	
<p>65. Name of informant: <u>John Doe</u></p>		<p>66. Address of informant: <u>Johns Hopkins</u></p>	
<p>67. Name of informant: <u>John Doe</u></p>		<p>68. Address of informant: <u>Johns Hopkins</u></p>	
<p>69. Name of informant: <u>John Doe</u></p>		<p>70. Address of informant: <u>Johns Hopkins</u></p>	
<p>71. Name of informant: <u>John Doe</u></p>		<p>72. Address of informant: <u>Johns Hopkins</u></p>	
<p>73. Name of informant: <u>John Doe</u></p>		<p>74. Address of informant: <u>Johns Hopkins</u></p>	
<p>75. Name of informant: <u>John Doe</u></p>		<p>76. Address of informant: <u>Johns Hopkins</u></p>	
<p>77. Name of informant: <u>John Doe</u></p>		<p>78. Address of informant: <u>Johns Hopkins</u></p>	
<p>79. Name of informant: <u>John Doe</u></p>		<p>80. Address of informant: <u>Johns Hopkins</u></p>	
<p>81. Name of informant: <u>John Doe</u></p>		<p>82. Address of informant: <u>Johns Hopkins</u></p>	
<p>83. Name of informant: <u>John Doe</u></p>		<p>84. Address of informant: <u>Johns Hopkins</u></p>	
<p>85. Name of informant: <u>John Doe</u></p>		<p>86. Address of informant: <u>Johns Hopkins</u></p>	
<p>87. Name of informant: <u>John Doe</u></p>		<p>88. Address of informant: <u>Johns Hopkins</u></p>	
<p>89. Name of informant: <u>John Doe</u></p>		<p>90. Address of informant: <u>Johns Hopkins</u></p>	
<p>91. Name of informant: <u>John Doe</u></p>		<p>92. Address of informant: <u>Johns Hopkins</u></p>	
<p>93. Name of informant: <u>John Doe</u></p>		<p>94. Address of informant: <u>Johns Hopkins</u></p>	
<p>95. Name of informant: <u>John Doe</u></p>		<p>96. Address of informant: <u>Johns Hopkins</u></p>	
<p>97. Name of informant: <u>John Doe</u></p>		<p>98. Address of informant: <u>Johns Hopkins</u></p>	
<p>99. Name of informant: <u>John Doe</u></p>		<p>100. Address of informant: <u>Johns Hopkins</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS 107
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08095

8193

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 20 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 504 Duke Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle Lou Last BOLLMANN		4. DATE OF DEATH Month July Day 17 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-60
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months 29	11. IF UNDER 24 HRS. Days 29 Hours 29 Min. 29
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard William BOLLMANN		14. MOTHER'S MAIDEN NAME Mary Jane REGAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Howard W. Bollmann, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) anomalous pulmonary venous return (c) and agenesis of right lung PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day 3 wks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from June 27 1960 to July 17 1960 , that 10 (we) lost 8:20 AM saw the deceased alive on July 17 19 60 , and that death occurred of M , from the causes and on the date stated above.			
22a. SIGNATURE G. B. Avery		22b. DATE SIGNED 6-17-60	
22c. PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20/60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisc. Ave., NW, WashDC		25a. REC'D BY REGISTRAR JUL 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kiana			

9VVVVVVVVVV

Feb 2001, Jan 2002

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8194

CERTIFICATE OF DEATH

Reg. Dist. No. 08096

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eliza Middle Elizabeth Last Boose				4. DATE OF DEATH Month July Day 9 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 27, 1890	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John Shoemaker				14. MOTHER'S MAIDEN NAME Alice King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-03-4658			
17. INFORMANT Catherine Smith				Address 16 Princeton Ave. Glen Echo, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardiovascular disease DUE TO (c) diabetes mellitus							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1, 1960 to July 9, 1960 that I last saw the deceased alive on July 8, 1960 , and that death occurred at 9:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stephen C. Cronwell M.D. 615 W. Montgomery Ave 7/9/60							
ACTUAL SIGNATURE Stephen C. Cronwell M.D. Rockville, Md.							
PHYSICIAN'S NAME (Type) Stephen C. Cronwell, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/12/60			
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				22d. LOCATION (City, town, or county) (State) Prince George Co. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. REC'D BY REGISTRAR Jul 12 '60			
ADDRESS Bethesda, Maryland				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

8194

CERTIFICATE OF DEATH

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1

NOTED: The above information was obtained from the records of the Department of Health, State of New York, and is subject to change.

NOTED: The above information was obtained from the records of the Department of Health, State of New York, and is subject to change.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8108

08097

1. PLACE OF DEATH a. COUNTY MONT GOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9216 WHITNEY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle WALTER Last BOYD		4. DATE OF DEATH Month JULY Day 17 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/13/98
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief of Program Services		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Fed. Credit Union	
11. BIRTHPLACE (State or foreign country) Omaha, Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM T. BOYD		14. MOTHER'S MAIDEN NAME PEARL ADELAIDE BILL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW # 1	
17. INFORMANT Mrs. Jessie P. Boyd, 9216 Whitney St., Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Insufficiency DUE TO 190.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Melanoma of Left Vitis DUE TO 2 years (c) 2 weeks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1958 to July 17, 1960 , that (I) (we) last saw the deceased alive on July 16, 1960 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John P. Haberlin		22b. DATE SIGNED 7-17-60	
22c. PHYSICIAN'S NAME (Type) JOHN P. HABERLIN		22d. ADDRESS 927 Pershing Drive Silver Spring	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/20/60	
23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond H. Ziska		ADDRESS SILVER SPRING, MD.	
25a. REC'D BY REGISTRAR JUL 22 '60		25b. REGISTRAR'S SIGNATURE Charles S. Harris	

Page 02

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8133

08098

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. SAN. Hosp.</u>				d. STREET ADDRESS <u>6121 8th st NW</u>			
3. NAME OF DECEASED (Type or print) <u>Michael A. Bozzi</u> First Middle Last				4. DATE OF DEATH Month <u>7</u> - Day <u>30</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Italian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1881</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Ricco Bozzi</u>		14. MOTHER'S MAIDEN NAME <u>XX? ROSA COSTA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-03-6873</u>		17. INFORMANT <u>Frank Bozzi</u> Address <u>321 Hillmoor Dr. S.S.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Coronary atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>12 hrs</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/28/60</u> to <u>7/30/60</u> , that (I) (we) last saw the deceased alive on <u>7/30/1960</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald Nelson</u>				22b. DATE SIGNED <u>7/30/60</u>		22c. PHYSICIAN'S NAME (Type) <u>DONALD NELSON</u>	
				22d. ADDRESS <u>10620 Georgia Ave. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/2/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>AUG 3 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles E. Pumphrey</u>			

101118

UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY MEDICAL DEPARTMENT
WASHINGTON, D. C. 20315

CERTIFICATE OF DEATH

8131

(M)

1. NAME (Last, first, middle initial) JAMES EARL RAY		2. SERVICE NUMBER 101118	
3. GRADE OR RATE Private		4. BRANCH Infantry	
5. DATE OF DEATH April 4, 1968		6. PLACE OF DEATH Memphis, Tennessee	
7. CAUSE OF DEATH Shot		8. MANNER OF DEATH Suicide	
9. SIGNATURE OF DECEASED James Earl Ray		10. SIGNATURE OF WITNESS [Signature]	
11. SIGNATURE OF PHYSICIAN [Signature]		12. SIGNATURE OF CHAPLAIN [Signature]	
13. SIGNATURE OF COMMANDER [Signature]		14. SIGNATURE OF MEDICAL OFFICER [Signature]	

OFFICE OF THE
CHIEF OF MEDICAL
DEPARTMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8195 CERTIFICATE OF DEATH 08099

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 119 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY 84X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean Park d. STREET ADDRESS Box 121 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gordon Leroy Brice		4. DATE OF DEATH Month July Day 27 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1913				
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager and Owner		10b. KIND OF BUSINESS OR INDUSTRY Motel Management					
11. BIRTHPLACE (State or foreign country) Washington		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Brice		14. MOTHER'S MAIDEN NAME Ada Koller					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable					
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage → shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Homologous serum hepatitis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 8 hours 1 week							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (the hospital) attended the deceased from March 30, 1960 to July 27, 1960 , that (I) (we) last saw the deceased alive on July 27, 1960 , and that death occurred at 8:25 AM from the causes and on the date stated above.							
22a. SIGNATURE Edward J. Laskowski		22b. DATE SIGNED 7/27/60					
22c. PHYSICIAN'S NAME (Type) Edward J. Laskowski, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit	23b. DATE THEREOF 7/28/1960	23c. NAME OF CEMETERY OR CREMATORY Ridgefield	23d. LOCATION (City, town, or county) (State) Clark County Washington				
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25. REC'D BY REGISTRAR DATE JUL 29 '60					
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

8179

CERTIFICATE OF DEATH

08100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b X Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13775 Travilah Road		d. STREET ADDRESS 13775 Travilah Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LILLY First MAY Middle BRIDGE Last		4. DATE OF DEATH July 16, Month 19 60 Day 19 60 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/1893
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Walter Grimes		14. MOTHER'S MAIDEN NAME Annie Grimes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Henry W. Bridge-Item#2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 44 3X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Ht. Failure DUE TO (c) Hypertension & A-S-CVD.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 8 hrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of breast - metastases		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1, 19 50 , to 7/16, 19 60 , that I last saw the deceased alive on 7/16, 19 60 , and that death occurred at 5:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen N. Jones		ADDRESS (Street, city or town, state) Rockville, Md DATE SIGNED 7/17/60	
PHYSICIAN'S NAME (Type) Stephen N. Jones		Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/19/60	22c. NAME OF CEMETERY OR CREMATORY Parklawn	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler-1331 E. Mtg. Ave.		ADDRESS Rockville, Maryland	
24a. REC'D BY REGISTRAR DATE JUL 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8170

(M)

[Faint, mostly illegible text on a form with horizontal lines. Some legible fragments include:]

Dec 11 1910

John A. Jones

Age 45

Residence 123 Main St.

Occupation Farmer

Cause of Death

Signature of Doctor

Signature of Registrar

Witness

(V)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8196
CERTIFICATE OF DEATH
08101

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON GROVE	
		d. STREET ADDRESS 313 BROWN STREET	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE LUCIAN BRIGHAM		4. DATE OF DEATH JULY 12 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/90
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Gen. Construction	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN T. BRIGHAM		14. MOTHER'S MAIDEN NAME ANNIE CROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578 05 5820	
17. INFORMANT HOSPITAL RECORDS,		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIAL HYPERTENSION DUE TO (c) CORONARY ARTERY DISEASE		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 20 YEARS 15 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS - GASTRIC ULCER		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MARCH 1950 to JULY 12 1960 , that (I) (we) last saw the deceased alive on JULY 12 1960 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Gordon S. Rosenberger		22b. DATE SIGNED JULY 13 1960	
22c. PHYSICIAN'S NAME (Type) GORDON S. ROSENBERGER, M. D.		22d. ADDRESS ROCKVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-15-60	
23c. NAME OF CEMETERY OR CREMATORY Darnestown Pres.		23d. LOCATION (City, town, or county) (State) Darnestown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		ADDRESS Laytonsville, Md.	
25a. REC'D BY REGISTRAR JUL 19 60		25b. REGISTRAR'S SIGNATURE Orin S. Kraus	

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1900
REPORT OF THE
COMMISSIONERS OF THE
DEPARTMENT OF HEALTH
ON THE
MORBIDITY AND MORTALITY
IN THE CITY OF NEW YORK
DURING THE YEAR 1899

1899

(14)

LABORATORY

WEEKLY

REPORTING LABORATORY

LABORATORY

LABORATORY

LABORATORY

LABORATORY

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LABORATORY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 7 Film G267 7/14/60 iwk									
Heart disease 8197									
CERTIFICATE OF DEATH									
Reg. Dist. No. 08102									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>2 1/2</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>4113 Knowles Avenue</u>				
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Wilfred</u> Last <u>Broadhurst</u>					4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1960</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/14/020</u>		9. AGE (In years lost birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Warthen & Ward</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co. Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James E. Broadhurst</u>					14. MOTHER'S MAIDEN NAME <u>Artie C. Hagar</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-16-0425</u>		INFORMANT <u>Ella E. Broadhurst</u>			Address <u>Wife same as above</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>454X</u> IMMEDIATE CAUSE (a) <u>Infarction, pons, right</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Thrombosis, Posterior communicating artery</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 days</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Bronchopneumonia</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1950</u> to <u>date</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6 July</u> , 19 <u>60</u> , and that death occurred at <u>5:05 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7936 Old Georgetown Rd.</u> DATE SIGNED <u>7/7/60</u> ACTUAL SIGNATURE <u>John G. Ball</u> M.D. <u>Bethesda, Maryland</u> PHYSICIAN'S NAME (Type) <u>John G. Ball, M. D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>					ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

WESTERN UNION TELEPHONE COMPANY
CENTRAL OFFICE
1911

TO THE BOARD OF DIRECTORS
OF THE WESTERN UNION TELEPHONE COMPANY
FROM THE BOARD OF DIRECTORS
OF THE WESTERN UNION TELEPHONE COMPANY
1911

THE BOARD OF DIRECTORS
OF THE WESTERN UNION TELEPHONE COMPANY
1911

THE BOARD OF DIRECTORS
OF THE WESTERN UNION TELEPHONE COMPANY
1911

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8198

Item 2, 267, 7-28-60 et

08103

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 23 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Virginia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leesburg, Box 356 d. STREET ADDRESS (Father is Supt. of the Home) Paxton Children's Home		
3. NAME OF DECEASED (Type or print) James Robert Buchanan			4. DATE OF DEATH Month July Day 21 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1951		9. AGE (In years last birthday) 8 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) California	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William R. Buchanan		
14. MOTHER'S MAIDEN NAME Eleanor Shaffer			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. None			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage and increased Intracranial Pressure. DUE TO (b) Central Nervous System Metastases DUE TO (c) Undifferentiated Small Cell Malignant Tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 199.2 INTERVAL BETWEEN ONSET AND DEATH 2 weeks Unknown 21 Months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonitis, Congestive Heart Failure; G I Bleeding					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from June 28 19 60 , to July 21 19 60 , that (I) (we) last saw the deceased alive on July 21 19 60 , and that death occurred at 3:45 A.M., from the causes and on the date stated above.					
22a. SIGNATURE Robert B. Scoggins		22b. DATE SIGNED 7-21-60		22c. PHYSICIAN'S NAME (Type) ROBERT B. SCOGGINS, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 23 July 1960		23c. NAME OF CEMETERY OR CREMATORY UNION	
23d. LOCATION (City, town, or county) (State) LEESBURG VA					
24. FUNERAL DIRECTOR'S SIGNATURE MUSE & LEE by Stanley Rud		25a. REC'D BY REGISTRAR JUL 25 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

8192

RECORD OF DEATH

1912

Virginia

Langley

Wendover

22 days

Holmes

The Clinical Center, Bethesda, Md., Eastern Division's Home

Woman

Robert

James

August 12, 1951

White

Male

None

Student

Director Center

William H. Bennett

The Medical Record

None The Clinical Center, Bethesda, Md., Eastern Division's Home

Intensive care, surgery and intensive care center

Examination

Central nervous system diseases

Examination

Intensive care, surgery and intensive care center

Examination

Intensive care, surgery and intensive care center

Examination

July 21 - July 22

July 21

1951-52

The Clinical Center, Bethesda, Md.

Intensive care, surgery and intensive care center

Intensive care, surgery and intensive care center

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

M

1
8161
MAYLAND
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08104

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Emory Grove</u>				d. STREET ADDRESS <u>Emory Grove</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rebecca</u> <u>Budd</u>				4. DATE OF DEATH Month Day Year <u>July</u> <u>21</u> <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-30-1903</u>	
9. AGE (In years, last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>Franz H. Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Brooke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Worick N. Budd - Item 2</u>		17. INFORMANT Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschaw</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Surode</u>				24a. REC'D BY REGISTRAR <u>JUL 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8109

08105

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8441 WOODCLIFF COURT		d. STREET ADDRESS 8441 WOODCLIFF COURT	
3. NAME OF DECEASED (Type or print) First LESTER Middle CHARLES Last BURDETT, SR.		4. DATE OF DEATH Month JULY Day 28 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/85
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Self-employed Insurance	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. MOTHER'S NAME FLETCHER BURDETT		14. MOTHER'S MAIDEN NAME SUSAN MANNIX	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-446539	
17. INFORMANT Mrs. Mary L. Burdett, 8441 Woodcliff Ct.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF THE PANCREAS 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-3-1954 to 7-28-1960 , that (I) (we) last saw the deceased alive on 7-27-1960 , and that death occurred at 11:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Jerome J. Krick		22b. DATE SIGNED 7/29/60	
22c. PHYSICIAN'S NAME (Type) JEROME J. KRICK		22d. ADDRESS 2800 Quebec Street, N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		23b. DATE THEREOF 7/30/60	
23c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY		23d. LOCATION (City, town, or county) (State) NYACK, NEW YORK	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Giska		25a. REC'D BY REGISTRAR DATE AUG 2 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

8110

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08106

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co</u> <u>Md.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>19149 Sligo Creek Parkway</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Althea Woodland Nursing Home</u>		d. STREET ADDRESS <u>Silver Spring, Md.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jeanette</u> Middle <u>Laura</u> Last <u>Burns</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Jacob Conrad</u>		14. MOTHER'S MAIDEN NAME <u>Neuhardt</u> <u>Caroline Neuhardt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Raymond Randolph Sanders</u>		Address <u>9149 Sligo Creek Pkwy, Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>congestive failure + arteriosclerosis</u> DUE TO (c) <u>Cachexia & senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 yrs -</u> <u>2 yrs -</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-4</u> , 19 <u>49</u> , to <u>7/29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/27</u> , 19 <u>60</u> , and that death occurred at <u>10/35</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8005 Woodbury Drive, Silver Spring, Md.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Nb Shoemaker</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Norman C. Shoemaker MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/1/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> <u>Raymond E. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

8110

CEPHALOPODS IN DEATH



[The main body of the document contains several paragraphs of text that are extremely faint and mostly illegible. The text appears to be a report or a list of observations related to cephalopods in a state of death. Some words like "cephalopods" and "death" are visible in the header, but the rest of the text is too faded to transcribe accurately.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8180

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08107

It-# 8 & 9 Film G267 7/15/60 iwk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 903 Lewis Avenue		d. STREET ADDRESS 903 Lewis Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Norman Middle R Last Campbell		4. DATE OF DEATH Month July Day 10 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/1895
9. AGE (In years last birthday) 75 65 yrs.		IF UNDER 1 YEAR Months 7 Days 5	IF UNDER 24 HRS. Hours 5 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Quebec Canada		12. CITIZEN OF WHAT COUNTRY? U/S/A/ Canada	
13. FATHER'S NAME Kenneth N Campbell		14. MOTHER'S MAIDEN NAME Isabelle MacDonald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 008-01-6659	
17. INFORMANT Mrs. Richard Tinsley-daughter-2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 7/11/60	
22c. NAME OF CEMETERY OR CREMATORY Wilson Cemetery		22d. LOCATION (City, lawn, or county) (State) Granetville, Vermont	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR 12 '60	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the funeral director, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEARBY AND STATE DEPARTMENT OF HEALTH-BALTIMORE IS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08108

CERTIFICATE OF DEATH

Reg. Dist. No.

8199

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>24 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hypothetical</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>11</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nona</u> Middle <u>Rhea</u> Last <u>Catron</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		12. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>James Powell</u>			
14. MOTHER'S MAIDEN NAME <u>Smallwood</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Harvey D. Catron, 5818 Undergriff Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>OCTOBER 1957</u> to <u>JULY 18, 1960</u> , that I last saw the deceased alive on <u>JULY 18, 1960</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>544 W. MONTGOMERY AVE. ROCKVILLE, MD.</u>							
ACTUAL SIGNATURE <u>William Frank</u>				DATE SIGNED <u>—</u>			
PHYSICIAN'S NAME (Type) <u>William Frank</u>				M.D. <u>544 W. MONTGOMERY AVE. ROCKVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Hilton, Barnesville</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

Dr Brochart, Notified

(M)

074

CERTIFICATE OF DEATH

8123

24 hours

Let the body be buried

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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8181
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08109

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 14 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) Waverly Sanitarium		d. STREET ADDRESS 3639 Windom Place, N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle M. Last CHAPMAN		4. DATE OF DEATH Month July Day 27 , Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1889
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months 11 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY C. & P. Tel. Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Edmund C. Chapman		14. MOTHER'S MAIDEN NAME Annie Boswell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. WW I	
17. INFORMANT Brother Walter G. Chapman		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerotic Cardiovascular Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis. DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1956 to July 27, 1960 that (I) (we) last saw the deceased alive on July 20, 1960 and that death occurred at 7 AM , from the cause and on the date stated above.			
22a. SIGNATURE John R. Ewan MD		22b. DATE SIGNED 7-27-60	
22c. PHYSICIAN'S NAME (Type) JOHN R. EWAN		22d. ADDRESS 1835 Eye St. N.W. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 7-29-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Tabernacle Church Cem.		23d. LOCATION (City, town, or county) (State) Bethesda, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR JUL 28 '60	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

MEDICAL CERTIFICATION



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8112

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>11 years</i>		d. STREET ADDRESS <i>2111 Spencer Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2111 Spencer Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lee Ross Christensen</i>		4. DATE OF DEATH <i>July 13 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/17/90</i>
9. AGE (In years, last birthday) <i>70 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. <i>5 26</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Legal</i>	
11. BIRTHPLACE (State or foreign country) <i>Utah</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>J. W. Christensen</i>		14. MOTHER'S MAIDEN NAME <i>Sanderson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes WW 1 & 2</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Virginia Reville</i>		Address <i>Boston Mass.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i> DUE TO <i>153.8</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of colon</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>—</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>None 19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6/28, 1960</i> , to <i>present</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>7/13</i> , 19 <i>60</i> , and that death occurred at <i>11:55 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Umhau</i> M.D.		ADDRESS (Street, city or town, state) <i>8805 CORVIN AVE.</i> DATE SIGNED <i>7/13/60</i>	
PHYSICIAN'S NAME (Type) <i>JOHN B. UMHAU</i>		<i>CHEY CHASE 15 MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-18-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>		ADDRESS <i>Bethesda, Md.</i>	
24a. REC'D BY REGISTRAR <i>JUL 15 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It is to be filed in the office of the Deputy Medical Examiner, who shall forward it to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

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MONTGOMERY
Sellman - RFD
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MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
08112

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sellman - RFD</u> c. LENGTH OF STAY IN 1b <u>60400</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sellman - RFD</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Ernest F Clagett</u>			4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1960</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>March 22 - 1893</u>		9. AGE (In years last birthday) <u>67</u> rs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Charles Clagett</u>			14. MOTHER'S MAIDEN NAME <u>Edmonia Ambush</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or defense service) <u>No</u>			16. SOCIAL SECURITY NO. <u>211-127063</u>		
17. INFORMANT <u>Bessie Clagett, Barnesville Md</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Crowning - occlusion -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular disease -</u> (c) <u>10 yr.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John B. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>CARVER MEMORIAL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>22 July 60.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>	
22d. LOCATION (City, town, or country) <u>Barnesville Md.</u>		22e. (State)			
23. FUNERAL DIRECTOR <u>William B. Hillen</u>		ADDRESS <u>Barnesville, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 26 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08113

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dickerson R7W</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>300 Adams Rd</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>Frederick md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>White Ferry</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jesse Lee Clark</u>		4. DATE OF DEATH <u>July 3 1960</u>	
5. SEX <u>male</u> <u>white</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-1921</u>	
9. AGE (In years, last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md. harystaten co</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willard H. Clark</u>		14. MOTHER'S MAIDEN NAME <u>Clara Wood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) <u>Yes WW2</u>		16. SOCIAL SECURITY NO. <u>220-05-1359</u>	
17. INFORMANT <u>Mrs Dale Carter - 302 Adams Rd, Frederick md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>sudden</u> (c) <u>sudden</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Boeschent</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BOESCHENT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>7-3-60</u>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 7, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

8202

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9710 Montank Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Adelbert J. Cole		4. DATE OF DEATH July 16, 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1910
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beau. of Standards		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Cole		14. MOTHER'S MAIDEN NAME Myrtle Cole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sarah B. Cole		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported to have taken ant poison (Cyanogas)	
20c. TIME OF INJURY Month, Day, Year 7/16/60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) Bethesda (County) Montg. Md. (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 7/17/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-20-60	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) Arden, Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C./		24. REC'D BY REGISTRAR JUL 19 1960 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Travis	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case not later than 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8203
CERTIFICATE OF DEATH

08115

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 7 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ronnie Middle Jax Last Collier				4. DATE OF DEATH Month July Day 30 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1960	
9. AGE (In years last birthday) 5		IF UNDER 1 YEAR Months 5 Days 17		IF UNDER 24 HRS. Hours 17 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Florida				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Ralph E. Collier				14. MOTHER'S MAIDEN NAME Christine Ray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombocytopenia DUE TO (c) Acute Myelogenous Leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Days Unknown 3 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 23 19 60 to July 30 19 60 that (I) (we) last saw the deceased alive on July 30 19 60 and that death occurred 1:35 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert B. Scoggins				22b. DATE SIGNED 7-30-60			
22c. PHYSICIAN'S NAME (Type) ROBERT B. SCOGGINS, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) SHIP RR.				23b. DATE THEREOF 7-31-60		23c. NAME OF CEMETERY OR CREMATORY GLENNVILLE, GA.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS 1400 Chapin St N.W.		25a. REC'D BY REGISTRAR DATE AUG 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

CERTIFICATE OF DEATH

2507

(M)

Florida

County

City

James H.

11 Days

The Clinical Center, Bethesda, Md., Md.

His last illness

Heart

Age

Sex

February 23, 1950

White

Male

Florida

Home

Work

Religion

Methodist

The Clinical Center, Bethesda, Md., Maryland

Age

Sex

Spontaneous

Internal

Acute

External

3 weeks

100

100

100

100

100

Robert D. Jones

Robert D. Jones, M.D.

The Clinical Center, Bethesda, Md., Maryland

2507

2507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

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8204

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08116

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Springfield e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Dorothy Freeman CONNOR		4. DATE OF DEATH Month Day Year July 19 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) 62 yrs.
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas FREEMAN		14. MOTHER'S MAIDEN NAME ELLEN JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sclerosis, amyotrophic lateral 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 12 1960 to July 19 1960 , that (I) (we) last saw the deceased alive on July 19 1960 , and that death occurred at 2:50 PM , from the causes and on the date stated above.			
22a. SIGNATURE M. E. Allison, Jr. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 7-19-60		22c. PHYSICIAN'S NAME (Type) M. E. ALLISON, JR., LCDR, MC, USN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 7-20-60	
23c. NAME OF CEMETERY OR CREMATORY Belmont Cemetery		23d. LOCATION (City, town, or county) (State) Belmont Massachusetts	
24. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons, 1756 Penn. Ave. NW, Wash DC <i>Joseph Gawler's Sons</i>		25a. REC'D BY REGISTRAR JUL 25 '60 25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8205

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08117

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 28 days d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Saint Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California d. STREET ADDRESS No street address e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Aucil Last Cooper		4. DATE OF DEATH Month July Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 3, 1873
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodsman		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James C. Cooper		14. MOTHER'S MAIDEN NAME Rachel Hensley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Hours			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 7, 1960 to July 5, 1960 , that (I) (we) last saw the deceased alive on July 5, 1960 , and that death occurred at 5:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE Michael Z. Lazor, M.D.		22b. DATE 7/6/60	
22c. PHYSICIAN'S NAME (Type) Michael Z. Lazor, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/60	
23c. NAME OF CEMETERY OR CREMATORY Valley Town Cem.		23d. LOCATION (City, town, or county) (State) Andrews, N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		25a. REC'D BY REGISTRAR DATE JUL 8 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

8207

(M)

United States

California

20 days

Refund

The United States, Refund 2, 1913

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8169
CERTIFICATE OF DEATH

08118

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanatorium</u>		d. STREET ADDRESS <u>2700 Wisconsin Avenue NW</u>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE HAMILTON</u>		4. DATE OF DEATH <u>JULY 18 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 December 1872</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>LOUISIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Hamilton</u>		14. MOTHER'S MAIDEN NAME <u>JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Emily Cole (daughter)</u>		Address <u>2700 Wisconsin Ave Washington, D.C. NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperpyrexia</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 18, 1955</u> to <u>July 18, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 18, 1960</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred Baer, M.D.</u>		22b. DATE SIGNED <u>July 18, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED BAER, M.D.</u>		22d. ADDRESS <u>2713 Wisconsin Avenue NW Washington 7, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/23/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cmn</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chang Chao</u>		ADDRESS <u>5103 1/2 1st Ave NW Wash DC</u>	
25a. REC'D BY REGISTRAR <u>Jul 22 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kneass</u>	

CERTIFICATE OF DEATH

2183

MADEIRA
HOSPITAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8206 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08119**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Co. b. COUNTY Washington, D.C.													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban				d. STREET ADDRESS 1019-10 th. St. N.E.													
3. NAME OF DECEASED (Type or print) First John Middle Crawford Last Crawford				4. DATE OF DEATH Month July Day 12 Year 1960													
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>													
8. DATE OF BIRTH Feb. 11, 1909		9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab orer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) South Carolina													
13. FATHER'S NAME John Crawford				14. MOTHER'S MAIDEN NAME Hattie (?)													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Ethel Crawford- Same as Above		17. INFORMANT Ethel Crawford- Same as Above													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td colspan="3"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination </td> <td colspan="3" rowspan="3"> INTERVAL BETWEEN ONSET AND DEATH Sudden 6 hours 6 hours </td> </tr> <tr> <td colspan="3"> 910.8 DUE TO Crushed Chest & Ruptured Liver </td> </tr> <tr> <td colspan="3"> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Compression by Cave-in </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination			INTERVAL BETWEEN ONSET AND DEATH Sudden 6 hours 6 hours			910.8 DUE TO Crushed Chest & Ruptured Liver			Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Compression by Cave-in		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination			INTERVAL BETWEEN ONSET AND DEATH Sudden 6 hours 6 hours														
910.8 DUE TO Crushed Chest & Ruptured Liver																	
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Compression by Cave-in																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Crushed in a cave-in on a construction job																	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crushed in a cave-in on a construction job															
20c. TIME OF INJURY Month, Day, Year 11:57 a.m. 7/12/60		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) construction job													
20f. (City or town) Silver Spring		20g. (County) Montg.		20h. (State) Md.													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>													
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>													
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 7/13/60													
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-16-60		22b. DATE THEREOF 7-16-60		22c. NAME OF CEMETERY OR CREMATORY Lancaster													
22d. LOCATION (City, town, or county) Lancaster		22e. (State) S.C.		22f. (Country) U.S.A.													
23. FUNERAL DIRECTOR'S SIGNATURE Frederic Funeral Home, 384 R.D. Ave. N.W.				24a. REC'D BY REGISTRAR JUL 18 '60													
24b. REGISTRAR'S SIGNATURE Arthur S. Hines				24c. (City, town, or county) Washington, D.C.													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
8508 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED John J. Smith		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH Baltimore, Md.		5. OCCUPATION Clerk		6. MARITAL STATUS Married	
7. DATE OF DEATH Feb. 11, 1931		8. TIME OF DEATH 10:30 A.M.		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Myocardial Infarction		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER J. H. Jones	
13. SIGNATURE OF NEXT OF KIN Mrs. J. J. Smith		14. SIGNATURE OF PHYSICIAN Dr. A. B. Brown		15. SIGNATURE OF BURIAL OFFICIAL Rev. C. D. Green	
16. SIGNATURE OF COUNTY CLERK John J. Smith		17. SIGNATURE OF CITY CLERK John J. Smith		18. SIGNATURE OF STATE CLERK John J. Smith	

8207

CERTIFICATE OF DEATH

Reg. Dist. No.

08120

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u>		c. LENGTH OF STAY IN 1b <u>3 wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Everest Care Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nelson</u> Middle <u>Hines</u> Last <u>Crouch</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20th</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3, 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u> Hours <u>15</u> Min.	11. IF UNDER 24 HRS. Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.B. & O. R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Crouch</u>		14. MOTHER'S MAIDEN NAME <u>Annie Ireland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-095335</u>	
17. INFORMANT <u>Samuel N. Crouch, son</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Infectious Dermatitis + Decubitus</u> DUE TO (c) <u>Sclerosis + senile inactivity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 5, 1960</u> to <u>July 20, 1960</u> , that I last saw the deceased alive on <u>July 20, 1960</u> , and that death occurred at <u>11:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur S. Sewell</u> M.D.		ADDRESS (Street, city or town, state) <u>Norbeck</u>	
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>		DATE SIGNED <u>7-20-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u>		ADDRESS <u>Mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

CERTIFICATE OF DEATH

250

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 15 1918*
5. Place of death: *Home*
6. Cause of death: *Heart Disease*
7. Signature of physician: *J. H. Smith*
8. Signature of registrar: *W. B. Jones*
9. Signature of informant: *M. E. Doe*
10. Date of registration: *Jan 16 1918*

WVGE 141111 8-11-18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08121

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 9 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 11613 Dewey Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jack Middle Owen S Last Crowe		4. DATE OF DEATH Month 7/1/60 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/39
9. AGE (In years last birthday) 29 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gasoline Station	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Gurney C. Crowe	
14. MOTHER'S MAIDEN NAME Irene Resh		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 218-24-8688		17. INFORMANT Address Md. Ellen M. Crowe, 11613 Dewey Road, Silver Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhages DUE TO 915.6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Contusions & lacerations DUE TO Multiple Skull Fractures PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Putting air in tire which exploded striking him in face			
INTERVAL BETWEEN ONSET AND DEATH 10 hours			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Putting air in tire which exploded striking him in face	
20c. TIME OF INJURY Month, Day, Year 7/1/60 Hour 7:05 a. m. PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Viers Mill Esso		20f. (City or town) Silver Spring Montg. (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschatt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschatt		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 2, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/5/60	22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Park	22d. LOCATION (City, town, or county) Cumberland Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland	
24a. REC'D BY REGISTRAR JUL 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

1
 8209
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08122

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 20 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ASHTON d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle JEANETTE Last CUFF				4. DATE OF DEATH Month JULY Day 27 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/28/89	9. AGE (In years lost birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND		
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME THOMAS R. JOHNSON			14. MOTHER'S MAIDEN NAME MARY ISABELLE TUCKER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) also: Chronic Nephritis DUE TO (c) 3 wks. yrs						INTERVAL BETWEEN ONSET AND DEATH 3 wks. yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Oct 19 59 to 7/27 19 60 , that (I) (we) last saw the deceased alive on 7/27 19 60 , and that death occurred at 8:00 P M, from the causes and on the date stated above.							
22a. SIGNATURE [Signature]			22b. DATE SIGNED 7/28/60				
22c. PHYSICIAN'S NAME (Type) CHARLES H. LIGON, M. D.			22d. ADDRESS SANDY SPRING, MD.				
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE THEREOF 7-30-60		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town, or county) (State) Burtonsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber			ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 2 '60		
					25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8210

08123

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4222 Massachusetts Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thornton</u> <u>Roosevelt</u> <u>Curry</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negroid</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22, 1922</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otho Curry</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1943 - 1946</u>		16. SOCIAL SECURITY NO. <u>1943 - 1946</u>	
17. INFORMANT <u>Mattie J. Curry</u>		Address <u>4222 Mass. Ave. S.E. WDC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>355X</u> IMMEDIATE CAUSE (a) <u>Brain lesion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 14 0600 AM 1960</u> to <u>July 16 1960</u>, that (I) (we) last saw the deceased alive on <u>July 16 1960</u>, and that death occurred at <u> </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Miller</u>		22b. DATE SIGNED <u>7-16-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. MILLER, LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-20-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT L. PLUMMER, RHINES & CO.</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 19 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frawley</u>			

CERTIFICATE OF DEATH

8210

Dec. 10, 1902

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8134

CERTIFICATE OF DEATH

Reg. Dist. No.

08124

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucille Dorothy Dahms</u>		4. DATE OF DEATH <u>July 10 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 17, 1912</u>
9. AGE (In years lost birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Therapist for a Psychiatrist</u>		11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>	
13. FATHER'S NAME <u>Thomas Dodds</u>		14. MOTHER'S MAIDEN NAME <u>Opal E. Wollery</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>447-229-275</u>	
17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.9 Krenia due to chst. metastases</u> DUE TO <u>Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General abdominal carcinomatosis</u> DUE TO <u>Carcinoma large bowel & ovary</u> (c) <u>3 months 6 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>60</u> , to <u>7/10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/9</u> , 19 <u>60</u> , and that death occurred at <u>6:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600 Carroll Ave - Th. Ok.</u> DATE SIGNED <u>July 10 1960</u>			
ACTUAL SIGNATURE <u>John F. Brownberger</u> M.D.		DATE SIGNED <u>July 10 1960</u>	
PHYSICIAN'S NAME (Type) <u>John F. Brownberger</u>		DATE SIGNED <u>July 10 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 15, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CHICKASHA CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>CHECKASHA, GRADY CO., OKLAHOMA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24. REC'D BY REGISTRAR <u>JUL 14 '60</u>	
ADDRESS <u>Warner E. Humphrey Inc. Silver Spring, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

8135

WILLIAM BROWN

AGE 60

RESIDENT OF BALTIMORE

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

PERMANENT CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

PERMANENT CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

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CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

PERMANENT CAUSE OF DEATH

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CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

PERMANENT CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b X Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammons Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALICE Middle LUCINDA Last DAVIS		4. DATE OF DEATH Month July Day 26 Year 19 60					
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1878	9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months 7 Days 19 Hours 00 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Henry Greene				14. MOTHER'S MAIDEN NAME Mary Eliza Greene			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Arthur S. Davis Address Gaithersburg, Md. Rt. 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure. 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Chronic Myocarditis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 60 , to July 16 , 19 60 , that I last saw the deceased alive on July 16 , 19 60 , and that death occurred at 7:00 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Luciano I. Leve M.D. 105 N. Frederick Ave PHYSICIAN'S NAME (Type) Luciano I. Leve Gaithersburg, Md.							
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 7/29/60		22c. NAME OF CEMETERY OR CREMATORY John Wesley.		22d. LOCATION (City, town, or county) (State) Rocky Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE AUG 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Davis	

CERTIFICATE OF DEATH

County of ...
State of ...

Heart Failure
Chronic Myocarditis

July 10, 1968
James A. ...
1000 ...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8170

08126

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VA. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 6 wks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens SAN.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle Poling Last Davis				4. DATE OF DEATH Month 7 Day 16 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1876	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 8 Days 3 Hours 3 Min.	IF UNDER 24 HRS. Months 8 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY West VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES WM. Poling				14. MOTHER'S MAIDEN NAME MARY JANE Houser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Address No	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Constrictive Heart FAILURE 4-2-0-0 DUE TO Arteriosclerotic Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sexuality DUE TO (c) Sexuality						INTERVAL BETWEEN ONSET AND DEATH 6 weeks yr yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 11 1960 to 7/16/60 , that (I) (we) last saw the deceased alive on 7/15/60 , and that death occurred at 12:30 P.M. M, from the causes and on the date stated above.							
22a. SIGNATURE SAM ALLEN, M.D. Kensington, Maryland				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/16/60	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF July 19, 1960		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, Inc. Dj. J. C. Bray				ADDRESS Arlington, Virginia		25a. REC'D BY REGISTRAR DATE JUL 18 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

8135

CERTIFICATE OF DEATH

08127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 4 1/2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanatorium + Hospital				d. STREET ADDRESS 8512 Manchester Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) WALTER STERNE DAVIS		First Middle Last		4. DATE OF DEATH 7 1 1960		Month Day Year	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-97	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE MANAGER		10b. KIND OF BUSINESS OR INDUSTRY Fed. Com. Comm.		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? Amer.	
13. FATHER'S NAME Edward F. Davis				14. MOTHER'S MAIDEN NAME Minnie Pope			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. --			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hypertensive Heart Disease DUE TO (c) year				INTERVAL BETWEEN ONSET AND DEATH Hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1953 , to June 30, 1960 , that I last saw the deceased alive on June 30, 1960 , and that death occurred at 2:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Istodre Shulman				ADDRESS (Street, city or town, state) 915-19th St. N. W.			
PHYSICIAN'S NAME (Type) ISIDORE SHULMAN				DATE SIGNED Wash. D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/5/60		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. BUMPHREY, INC. Raymond R. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JUL 6 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8136

CERTIFICATE OF DEATH

Reg. Dist. No.

08128

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. & Hosp.</i>		e. STREET ADDRESS <i>18403 Roanoke Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Jack</i> Middle <i>Zavar</i> Last <i>Demirdjian</i>		4. DATE OF DEATH Month <i>July</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>June 24-1914</i> 9. AGE (In years lost birthday) <i>46</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Rhode Island</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Aarhon Demirdjian</i>		14. MOTHER'S MAIDEN NAME <i>Mary Pakradoonian</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Unknown</i> 17. INFORMANT <i>Hospital Records</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fibrillation - (ventricular) Failure</i> DUE TO <i>416X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adherens - Extensive Pericardial</i> DUE TO <i>Conduction system</i> (c) <i>5 years</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-16-</i> , 19 <i>60</i> , to <i>7-11-</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>7-11-</i> , 19 <i>60</i> , and that death occurred at <i>10:00 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Hare</i>		ADDRESS (Street, city or town, state) <i>7600 Carroll Ave, Tak. Park, Md</i> DATE SIGNED <i>7/13/60</i>	
PHYSICIAN'S NAME (Type) <i>Robert A. Hare</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-16-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Wash Natl Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers & Co</i> ADDRESS <i>1400 Chapin St</i>		24a. RECD BY REGISTRAR <i>7/20</i> 24b. REGISTRAR'S SIGNATURE <i>Charles E. Kane</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>	
DATE OF DEATH <i>Jan 15 1925</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart Disease</i>		DISEASE OR INJURY <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>	
DATE OF SIGNATURE <i>Jan 15 1925</i>		DATE OF SIGNATURE <i>Jan 15 1925</i>		DATE OF SIGNATURE <i>Jan 15 1925</i>	
PLACE OF SIGNATURE <i>Baltimore</i>		PLACE OF SIGNATURE <i>Baltimore</i>		PLACE OF SIGNATURE <i>Baltimore</i>	
NAME OF PHYSICIAN <i>J. H. Smith</i>		NAME OF WITNESS <i>John Doe</i>		NAME OF DECEASED <i>John Doe</i>	
ADDRESS OF PHYSICIAN <i>123 Main St</i>		ADDRESS OF WITNESS <i>456 Main St</i>		ADDRESS OF DECEASED <i>789 Main St</i>	
CITY OF PHYSICIAN <i>Baltimore</i>		CITY OF WITNESS <i>Baltimore</i>		CITY OF DECEASED <i>Baltimore</i>	
STATE OF PHYSICIAN <i>Md</i>		STATE OF WITNESS <i>Md</i>		STATE OF DECEASED <i>Md</i>	
COUNTY OF PHYSICIAN <i>Baltimore</i>		COUNTY OF WITNESS <i>Baltimore</i>		COUNTY OF DECEASED <i>Baltimore</i>	
ZIP CODE OF PHYSICIAN <i>21201</i>		ZIP CODE OF WITNESS <i>21201</i>		ZIP CODE OF DECEASED <i>21201</i>	
FEDERAL BUREAU OF INVESTIGATION <i>123 Main St</i>		FEDERAL BUREAU OF INVESTIGATION <i>456 Main St</i>		FEDERAL BUREAU OF INVESTIGATION <i>789 Main St</i>	
CITY OF FBI <i>Baltimore</i>		CITY OF FBI <i>Baltimore</i>		CITY OF FBI <i>Baltimore</i>	
STATE OF FBI <i>Md</i>		STATE OF FBI <i>Md</i>		STATE OF FBI <i>Md</i>	
COUNTY OF FBI <i>Baltimore</i>		COUNTY OF FBI <i>Baltimore</i>		COUNTY OF FBI <i>Baltimore</i>	
ZIP CODE OF FBI <i>21201</i>		ZIP CODE OF FBI <i>21201</i>		ZIP CODE OF FBI <i>21201</i>	
FEDERAL BUREAU OF INVESTIGATION <i>123 Main St</i>		FEDERAL BUREAU OF INVESTIGATION <i>456 Main St</i>		FEDERAL BUREAU OF INVESTIGATION <i>789 Main St</i>	
CITY OF FBI <i>Baltimore</i>		CITY OF FBI <i>Baltimore</i>		CITY OF FBI <i>Baltimore</i>	
STATE OF FBI <i>Md</i>		STATE OF FBI <i>Md</i>		STATE OF FBI <i>Md</i>	
COUNTY OF FBI <i>Baltimore</i>		COUNTY OF FBI <i>Baltimore</i>		COUNTY OF FBI <i>Baltimore</i>	
ZIP CODE OF FBI <i>21201</i>		ZIP CODE OF FBI <i>21201</i>		ZIP CODE OF FBI <i>21201</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08129

8211

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>7220 BARNETT RD.</u>			
3. NAME OF DECEASED (Type or print) <u>BESSIE AMANDA DIAMOND</u>				4. DATE OF DEATH <u>JULY 5, 1960</u> 19 <u>60</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 18, 1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u>17</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>USA. Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas Kinkie</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. Kneeder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Nurse Betty J. Procono</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4:30 P.M.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-----</u> DUE TO (c) <u>-----</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>-----</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-6-1960</u> to <u>7-5-1960</u> , that (I) (we) last saw the deceased alive on <u>7-4-1960</u> and that death occurred at <u>3:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles House</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-5-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles House</u>				22d. ADDRESS <u>7701 Carroll Ave T.P. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/6/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Saviour Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>York County, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 7 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

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CELESTINE CAROL W. DEAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
8212
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08130

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 6 HRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS 13X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HERBERT		First CARVEL		Last DIAMOND		4. DATE OF DEATH Month JULY Day 26 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/9/12		9. AGE (In years lost birthday) 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HERBERT LAWRENCE DIAMOND				14. MOTHER'S MAIDEN NAME MARIE JONES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 195.0 IMMEDIATE CAUSE (a) CARCINOMA OF THE LEFT ADRENAL WITH METASTASES DUE TO TO LIVER AND LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BILATERAL LOBAR PNEUMONIA						INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from SEPT. 10, 1959 to JULY 26, 1960 that (I) (we) lost saw the deceased alive on JULY 25, 1960 , and that death occurred at 12:50 A. M, from the causes and on the date stated above.							
22a. SIGNATURE Charles S. Whitaker, M.D. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/26/60	
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D.				22d. ADDRESS CLARKSVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-28-60		23c. NAME OF CEMETERY OR CREMATORY St. Rose.		23d. LOCATION (City, town, or county) (State) Gaithersburg. Rural. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.				25a. REC'D BY REGISTRAR JUL 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

8218

CERTIFICATE OF DEATH

08711



DEPARTMENT

NAVY

WARD

NAME

AGE

SEX

RESIDENT

CIVIL

STATUS

DATE

MALE

WHITE

WIDOW

#1

ADDRESS

NAVY

DEPARTMENT OF THE ARMY

NAVY

HOSPITAL RECORD, 1911, 1912

RECORDS OF THE DEPT. OF THE ARMY
TO LIVE AND LEAVE

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may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove card and papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8213

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08131

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. STATE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS ROUTE #2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BRYON Middle DEAN Last DOBSON		4. DATE OF DEATH Month JULY Day 22 Year 1960					
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-60	9. AGE (In years last birthday) 4 DAYS	IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES EDWARD DOBSON				14. MOTHER'S/MAIDEN NAME JEAN ELOISE MURRAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO fractures Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE W. A. LINTHICUM, M. D.				22b. DATE SIGNED 7/23/60		22c. PHYSICIAN'S NAME (Type) W. A. LINTHICUM, M. D.	
22d. ADDRESS ROCKVILLE, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE THEREOF 7/25/60		23c. NAME OF CEMETERY OR CREMATORY Emory Grove.,		23d. LOCATION (City, town, or county) (State) Emory Grove, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sundt				25a. REC'D BY REGISTRAR DATE JUL 27 '60		25b. REGISTRAR'S SIGNATURE William S. Frank	

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CERTIFICATE OF DEATH

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DEPARTMENT OF HEALTH
 COUNTY OF ALBANY
 CITY OF ALBANY
 DEATH OF
 NAME OF DECEASED
 SEX
 AGE
 DATE OF DEATH
 PLACE OF DEATH
 CAUSE OF DEATH
 TIME OF DEATH
 SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES
 SIGNATURE OF MINISTER OF THE GOSPEL
 SIGNATURE OF CLERGYMAN
 SIGNATURE OF JUDGE
 SIGNATURE OF SHERIFF
 SIGNATURE OF CLERK
 SIGNATURE OF NOTARY PUBLIC
 SIGNATURE OF ATTORNEY AT LAW
 SIGNATURE OF PHYSICIAN
 SIGNATURE OF SURGEON
 SIGNATURE OF DENTIST
 SIGNATURE OF VETERINARIAN
 SIGNATURE OF MIDWIFE
 SIGNATURE OF NURSE
 SIGNATURE OF PHARMACEUTICAL PREPARER
 SIGNATURE OF OPTICIAN
 SIGNATURE OF OPTOMETRIST
 SIGNATURE OF DENTIST
 SIGNATURE OF VETERINARIAN
 SIGNATURE OF MIDWIFE
 SIGNATURE OF NURSE
 SIGNATURE OF PHARMACEUTICAL PREPARER
 SIGNATURE OF OPTICIAN
 SIGNATURE OF OPTOMETRIST

DECEASED

JAMES JOHN ROBERTSON

DECEASED

DECEASED

DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9-59

8214

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08132

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS ROUTE #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BYRON Middle EUGENE Last DOBSON				4. DATE OF DEATH Month JULY Day 23 Year 1960			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-60		9. AGE (In years last birthday) 4 DAYS yrs.	IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		
13. FATHER'S NAME JAMES EDWARD DOBSON				14. MOTHER'S MAIDEN NAME JEAN ELOISE MURRAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) Bacteremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH few hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE W. A. Linthicum		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/23/60			
22c. PHYSICIAN'S NAME (Type) W. A. LINTHICUM, M. D.		22d. ADDRESS ROCKVILLE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/25/60		23c. NAME OF CEMETERY OR CREMATORY Emory Grove.,			
23d. LOCATION (City, town, or county) (State) Emory Grove, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surdick ADDRESS Rockville, Md.					
25a. REC'D BY REGISTRAR DATE JUL 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

2173212XV3

CERTIFICATE OF DEATH

1884

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8215

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08133

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 81 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 9016 Autoville Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Katherine Middle Louise Last Donald				4. DATE OF DEATH Month July Day 10 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1953	
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Months 7 Days 10 Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Donald				14. MOTHER'S MAIDEN NAME Elizabeth Goldsworthy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral and Subdural Hemorrhage DUE TO (b) Cerebral Metastases of Reticulum Cell Sarcoma. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Terminal Ileitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Terminal Ileitis							
INTERVAL BETWEEN ONSET AND DEATH 5 days							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11:15 p. m. 60				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 20 19 60 to July 10 19 60 that (I) (we) last saw the deceased alive on July 10 19 60 and that death occurred at 11:15 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Jerome B. Block				22b. DATE SIGNED 7-11-60			
22c. PHYSICIAN'S NAME (Type) JEROME B. BLOCK, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 14, 1960		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Pr. Geo. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. ADDRESS Quindale, Md.				25a. REC'D BY REGISTRAR DATE JUL 15 '60		25b. REGISTRAR'S SIGNATURE W. S. Kline	

4

1

8158

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. LENGTH OF STAY IN 1b 51 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "HAYES"-MANOR ROAD		d. STREET ADDRESS "HAYES"-MANOR ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE THOMAS DUNLOP		4. DATE OF DEATH Month Day Year JULY 4th 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/1870
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		10b. KIND OF BUSINESS OR INDUSTRY TRANS IT	
11. BIRTHPLACE (State or foreign country) FREDERICK Co., MD.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME GEORGE THOMAS DUNLOP		14. MOTHER'S MAIDEN NAME EMILY REDIN KIRK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT A. McCook Dunlop (same as above)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ARTERIOSCLEROSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 332X DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from approx. 11:30 PM to JULY 4, 1960 , that (I) (we) last saw the deceased alive on JULY 4, 1960 , and that death occurred at 11:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE H. D. Ecker		22b. DATE SIGNED 7/5/60	
22c. PHYSICIAN'S NAME (Type) Henry D. Ecker, M.D.		22d. ADDRESS 917-20th St. N.W., Washington 6, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7-7-1960	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Rudolph Inc.		25a. REC'D BY REGISTRAR DATE JUL 7 '60	
ADDRESS 1756 Pa. Ave. N.W.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CEREBRAL ARTERIOSCLEROSIS 2 + yrs

AMICK Junior (same as above)

Emily Rebin Kirk

FREDERICK CO, MD. L.S.H.

9/25/870 83

Junior

HAYES-MANOR ROAD

CHEVY CHASE

MARIAND

WESTMINSTER

TRANSIT

GEORGE THOMAS DUNLOP

ATTORNEY

MALE WHITE

GEORGE

THOMAS

"HAYES-MANOR" ROAD

CHEVY CHASE

WESTMINSTER

JULY 4 60

W. Ecker

Henry D. Ecker, M.D.

417-20th St. N.W. Washington D.C.

Oppier 11.22 AM

JULY 4 60

7/5/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

8137

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08135

Phone call, see item 21, et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				d. STREET ADDRESS <u>220 Capitol Cres</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Edward Sunnington</u>				4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-24-85</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cameo Furniture Co.</u>		9. AGE (In years last birthday) <u>74</u> yrs.			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>					
13. FATHER'S NAME <u>George Sunnington</u>				14. MOTHER'S MAIDEN NAME <u>Blanche Mattingly</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>517-18-9746</u>		17. INFORMANT <u>Pt Hosp Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>July 8</u> 19 <u>60</u> to <u>July 25</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>July 24</u> 19 <u>60</u> , and that death occurred at <u>4P</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>				22b. DATE SIGNED <u>7-25-60</u>					
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>				22d. ADDRESS <u>217 University Blvd E. SS Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey Inc.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 29 '60</u>			
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

10120

8137

AMERICAN AIR DEPARTMENT OF HEALTH
OFFICE OF PUBLIC HEALTH AND SAFETY
WASHINGTON, D. C.

CERTIFICATE OF DEATH

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
8216 See: Birth Cert.
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

08136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 hrs. 30 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>GIRL "A"</u> Last <u>Early</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1960</u>
9. AGE (In years, last birthday) <u>3 3/4</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Paul L. Early</u>		14. MOTHER'S M maiden NAME <u>Barrers, Nancy Leona</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>father above.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis, Pulmonary</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u> (c) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 hrs</u> <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1:30 AM 7-8-60</u> to <u>4:45 AM 7-8-1960</u> that I last saw the deceased alive on <u>7-8-60</u> and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis J. Troendle</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd Rockville, Md</u> DATE SIGNED <u>7-8-60</u>	
PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>		<u>809 Viers Mill Rd. Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>7-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	
DATE <u>12 '60</u>			

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CERTIFICATE OF DEATH

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8217 See: Birth Cert.
CERTIFICATE OF DEATH

Reg. Dist. No. 08137

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>8hrs. 35min</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German town</u> d. STREET ADDRESS <u>1 P. O. By 42</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>"B" Earley</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1960</u>
9. AGE (In years last birthday) <u>8hrs. 35 yrs.</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>35</u> Hours <u>35</u> Min. <u>35</u>	IF UNDER 24 HRS. Months <u>8</u> Days <u>35</u> Hours <u>35</u> Min. <u>35</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>U.S. Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Paul L. Earley</u>	
14. MOTHER'S MAIDEN NAME <u>Burkess, Nancy Leona</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>father - above</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis, Pulmonary</u> DUE TO <u>Immaturity</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>8 hrs</u> <u>8 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>13 AM 7-8, 1960</u> to <u>9 AM 7-8, 1960</u> , that I last saw the deceased alive on <u>7-8, 1960</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis J. Troendle</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville Md</u> DATE SIGNED <u>7-8-60</u>	
PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>		<u>809 Viers Mill Rd. Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>7-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) <u>Bethesda, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital 8600 O'Connell Rd</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Jul 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

8217



[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. There are also lines for the signature of the attending physician and the registrar.]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AJS (4)
15M/9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8218

CERTIFICATE OF DEATH

08138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>May, 1959 - 1960</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Eckles</u> Last <u>Eckles</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1960</u>
9. AGE (In years lost birthday) <u>1</u> yrs. <u>7</u> months <u>7</u> days <u>7</u> hours <u>7</u> min.		10. AGE (In years lost birthday) <u>1</u> yrs. <u>7</u> months <u>7</u> days <u>7</u> hours <u>7</u> min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Stanley Eckles</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Rowe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mother's chart -</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cardiac Deletion</u> (c) <u>Hypoglycemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1-</u> , 19 <u>60</u> , to <u>7-2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5 PM on 7-2, 1960</u> , and that death occurred at <u>7:50 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis J. Troendle</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd Rockville, Md.</u> DATE SIGNED <u>7/2/60</u>	
PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>		<u>809 Viers Mill Rd. Rockville 7/2/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Jul 6 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

2074 283 X V 6

DATE

Blank form with faint horizontal lines for text entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8219

08139

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RICHARD Middle B. Last EDELEN		4. DATE OF DEATH Month July Day 27 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Philip Edelen		14. MOTHER'S MAIDEN NAME Fannie Steed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Son		Address R. Edwin Edelen	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO years (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 19 56 to July 27 19 60 that (I) (we) lost the deceased alive on July 26 19 60 , and that death occurred at 11 AM , from the causes and on the date stated above.			
22a. SIGNATURE Wilfred R. Ehrmentraut M.D.		22b. DATE SIGNED July 27, 1960	
22c. PHYSICIAN'S NAME (Type) Wilfred R. Ehrmentraut		22d. ADDRESS 3890 Battery Lane, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/30/60	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem		23d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR JUL 28 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

8219

CERTIFICATE OF DEATH

0819

WILLIAM H. BARNETT, JR.
Age 35
Born 10/10/1900
Residence 1000 Madison Ave., New York, N.Y.
Cause of Death: Myocardial Infarction
Date of Death: 10/25/1935
Place of Death: St. Luke's Hospital, New York, N.Y.
Physician: Dr. J. H. Smith
Burial: St. John's Cemetery, New York, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8220

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08140

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Iowa b. COUNTY Keokuk ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 165 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keola		53X-3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS Box 224		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Bergie Middle Louava Last Evans			4. DATE OF DEATH Month July Day 8 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 22, 1891	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Alvin L. Fry			14. MOTHER'S MAIDEN NAME Myrtee Reed		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO 205X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastases to Heart DUE TO (c) Mycosis Fungoides					INTERVAL BETWEEN ONSET AND DEATH 2 weeks Unknown 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from January 25, 1960 to July 8, 1960 , that (I) (we) last saw the deceased alive on July 8, 1960 , and that death occurred at 11:37 P.M. causes and on the date stated above.					
22a. SIGNATURE Jerome B. Block		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/9/60	
22c. PHYSICIAN'S NAME (Type) JEROME B. BLOCK, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		23b. DATE THEREOF 7/10/60		23c. NAME OF CEMETERY OR CREMATORY Keota Cemetery	
23d. LOCATION (City, town, or county) (State) Keota, Iowa					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUL 12 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

CERTIFICATE OF BIRTH

1. Name of child: [illegible]
2. Sex: [illegible]
3. Date of birth: [illegible]
4. Place of birth: [illegible]
5. Name of father: [illegible]
6. Name of mother: [illegible]
7. Name of attending physician: [illegible]
8. Name of hospital: [illegible]
9. Name of doctor: [illegible]
10. Name of nurse: [illegible]
11. Name of midwife: [illegible]
12. Name of other attendant: [illegible]
13. Name of registrar: [illegible]
14. Name of clerk: [illegible]
15. Name of stenographer: [illegible]
16. Name of typewriter: [illegible]
17. Name of printer: [illegible]
18. Name of binder: [illegible]
19. Name of folder: [illegible]
20. Name of envelope: [illegible]
21. Name of box: [illegible]
22. Name of cabinet: [illegible]
23. Name of desk: [illegible]
24. Name of chair: [illegible]
25. Name of table: [illegible]
26. Name of lamp: [illegible]
27. Name of clock: [illegible]
28. Name of calendar: [illegible]
29. Name of telephone: [illegible]
30. Name of radio: [illegible]
31. Name of television: [illegible]
32. Name of refrigerator: [illegible]
33. Name of stove: [illegible]
34. Name of sink: [illegible]
35. Name of toilet: [illegible]
36. Name of bathtub: [illegible]
37. Name of bed: [illegible]
38. Name of dresser: [illegible]
39. Name of wardrobe: [illegible]
40. Name of closet: [illegible]
41. Name of hallway: [illegible]
42. Name of kitchen: [illegible]
43. Name of living room: [illegible]
44. Name of bedroom: [illegible]
45. Name of bathroom: [illegible]
46. Name of porch: [illegible]
47. Name of garage: [illegible]
48. Name of driveway: [illegible]
49. Name of street: [illegible]
50. Name of city: [illegible]
51. Name of state: [illegible]
52. Name of country: [illegible]

1. Name of child: [illegible]
2. Sex: [illegible]
3. Date of birth: [illegible]
4. Place of birth: [illegible]
5. Name of father: [illegible]
6. Name of mother: [illegible]
7. Name of attending physician: [illegible]
8. Name of hospital: [illegible]
9. Name of doctor: [illegible]
10. Name of nurse: [illegible]
11. Name of midwife: [illegible]
12. Name of other attendant: [illegible]
13. Name of registrar: [illegible]
14. Name of clerk: [illegible]
15. Name of stenographer: [illegible]
16. Name of typewriter: [illegible]
17. Name of printer: [illegible]
18. Name of binder: [illegible]
19. Name of folder: [illegible]
20. Name of envelope: [illegible]
21. Name of box: [illegible]
22. Name of cabinet: [illegible]
23. Name of desk: [illegible]
24. Name of chair: [illegible]
25. Name of table: [illegible]
26. Name of lamp: [illegible]
27. Name of clock: [illegible]
28. Name of calendar: [illegible]
29. Name of telephone: [illegible]
30. Name of radio: [illegible]
31. Name of television: [illegible]
32. Name of refrigerator: [illegible]
33. Name of stove: [illegible]
34. Name of sink: [illegible]
35. Name of toilet: [illegible]
36. Name of bathtub: [illegible]
37. Name of bed: [illegible]
38. Name of dresser: [illegible]
39. Name of wardrobe: [illegible]
40. Name of closet: [illegible]
41. Name of hallway: [illegible]
42. Name of kitchen: [illegible]
43. Name of living room: [illegible]
44. Name of bedroom: [illegible]
45. Name of bathroom: [illegible]
46. Name of porch: [illegible]
47. Name of garage: [illegible]
48. Name of driveway: [illegible]
49. Name of street: [illegible]
50. Name of city: [illegible]
51. Name of state: [illegible]
52. Name of country: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8221

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08141

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 9 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 617 Blandford Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Kathleen Middle FERRIS Last FERRIS		4. DATE OF DEATH Month July Day 16 Year 1960					
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-60	9. AGE (In years last birthday) 9	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS. Days 9	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Douglas G. FERRIS		14. MOTHER'S MAIDEN NAME Joyce N. BAKER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Douglas Ferris (F), same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis Fetalis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 77 0.5 DUE TO (c) 77 0.5						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity and Immaturity						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from July 16 1960 to July 16 1960 , that (I) yes last saw the deceased alive on July 16 1960 , and that death occurred at 10:30AM M, from the causes and on the date stated above.							
22a. SIGNATURE Fred W Grello		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-16-60			
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20/60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisconsin Ave., N.W.				25a. REC'D BY REGISTRAR JUL 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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100-1

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
DIVISION OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
WASHINGTON, D. C.

1952

(M)

Birth Certificate
No. 100-1
Date of Birth
Place of Birth
Sex
Race
Color
Religion
Marital Status
Occupation
Education
Parent's Name
Mother's Name
Signature of Registrar

1

Official Seal of the Registrar
Date of Issuance
Signature of Registrar

Official Seal of the Registrar

Official Seal of the Registrar

Official Seal of the Registrar

Official Seal of the Registrar

Official Seal of the Registrar

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8222 Item 7 Film G268 8-8-60 et
CERTIFICATE OF DEATH

Reg. Dist. No. **08142**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 90 days 10 hrs. 34	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
f. STREET ADDRESS 12408 Ga. Ave.		g. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William E. Fields		4. DATE OF DEATH Month July Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/73
9. AGE (In years lost birthday) yrs. 86		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Montgomery County	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Rash Fields		14. MOTHER'S MAIDEN NAME Mary Elizabeth Fields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 578-10-7835	
17. INFORMANT Mrs. Charles Causy		Address 12408 Ga. Ave. S. S. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestive Heart Failure DUE TO (b) Generalized atherosclerosis DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Prostatic Hypertrophy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 July , 19 60 , to 29 July , 19 60 , that I last saw the deceased alive on 29 July , 19 60 , and that death occurred at 8:10 A. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Michael Dobridge		ADDRESS (Street, city or town, state) 10620 Georgia Ave. Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Michael Dobridge		DATE SIGNED Aug 3 '60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/1/60	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR AUG 3 '60		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	

ORIGINAL FILED

8282

CERTIFICATE OF DEATH

1914

DEPARTMENT OF HEALTH

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

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14
FOR STATE
HEALTH DEPT.

8113

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08143
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b since 6/24/44 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13,420 Ga. Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 SILVER SPRING d. STREET ADDRESS 13,420 Ga. Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELSA LOHMANN FINNEY		4. DATE OF DEATH Month JULY Day 27 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/11/98
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher - retired		10b. KIND OF BUSINESS OR INDUSTRY D. C. Schools	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JASPER LOHMANN		14. MOTHER'S MAIDEN NAME CLARA SONNENBERG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Doyal D. Finney, 13,420 Ga. Ave. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Crowning Infarction Conditions, if any, which gave rise to immediate cause (b) Cardio Vascular Disease (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hr.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		DATE SIGNED 27 July 60	
EXAMINER'S NAME (Type) JOHN G. BALL		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/30/60	22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond E. Ziska		24a. REC'D BY REGISTRAR DATE AUG 1 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

TO ALL DIRECTORS OF HEALTH DEPARTMENTS
IN THE UNITED STATES
AND TO ALL REGISTRARS OF VITAL STATISTICS
IN THE DISTRICT OF COLUMBIA

8113

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John A. Smith</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF DEATH <i>Jan 15 1918</i>		PLACE OF DEATH <i>Home</i>	
RESIDENCE <i>123 Main St. Baltimore, Md.</i>		OCCUPATION <i>Teacher</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		RELIGION <i>Methodist</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		SYMPTOMS <i>Chest pain, shortness of breath</i>		TREATMENT <i>Medical</i>		HISTORY <i>None</i>		FAMILY HISTORY <i>None</i>	
SIGNATURE OF EXAMINER <i>J. B. Smith</i>		DATE <i>Jan 15 1918</i>		PLACE <i>Baltimore, Md.</i>		TITLE <i>Medical Examiner</i>		COUNTY <i>Baltimore</i>		STATE <i>Md.</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08144**

8114

FOR STATE
HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 5 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13111 Superior St		e. STREET ADDRESS 13111 Superior St	
3. NAME OF DECEASED (Type or print) Ruth Adelia Franklin		4. DATE OF DEATH Month July Day 5 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1919
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Minn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leander -Leonander Mattson		14. MOTHER'S MAIDEN NAME Mary Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES [If yes, give war or dates of service] WW # 2		16. SOCIAL SECURITY NO. 394-20-0825	
17. INFORMANT David L. Franklin (husband)		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Rheumatic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4/16X (c) 4/16X			INTERVAL BETWEEN ONSET AND DEATH hrs. months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF July 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

FOR STATE
HEALTH UNIT



1

ALL INFORMATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8114

DECEASED

Maryland

Alive - State

5 Year

Living Spouse

John Doe

John Doe

Color of Skin

White

Sex

Male

Occupation

Farmer

Married

Married

Wife

Wife

Cause of Death

Heart Disease

Age

65

Sex

Male

Color of Skin

White

Sex

Male

Occupation

Farmer

Married

Married

Wife

Wife

Color of Skin

White

Sex

Male

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8171

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08145

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>				d. STREET ADDRESS <u>1954 Rosemary Hills Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALICE</u> First <u>MAY</u> Middle <u>FREEMAN</u> Last		4. DATE OF DEATH <u>July</u> Month <u>29</u> Day <u>1960</u> Year					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1900</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hotel manager</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Raleigh Brock</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Atkinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>578-46-8468</u>		17. INFORMANT <u>Halter Freeman</u> Address <u>1954 Rosemary Hills Dr. Silver Springs, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO <u>Melancholy.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of lungs + pelvic bones</u> (c) <u>1 1/2 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ovarian, Secondary.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1955</u> to <u>7/29/60</u> , that (I) (we) last saw the deceased alive on <u>7/28/60</u> 19 <u>60</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James A. O'Keefe MD</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>7/29/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>James A. O'Keefe MD</u>				22d. ADDRESS <u>4501-Corn. Ave. NW. Washington DC.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>August 2, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. Jones</u> ADDRESS <u>2847 Wilson Blvd. Arlington, Virginia</u>				25a. REC'D BY REGISTRAR <u>AUG 1 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

1951

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Washington, D.C.

Mary Catherine Robinson

William Robert Brock

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8223

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08146

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b DOA USA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
3. NAME OF DECEASED (Type or print) First William Middle Francis Last FURRY, JR.		4. DATE OF DEATH Month July Day 1 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/41
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY GAS STATION ATTENDANT	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANCIS FURRY, SR.		14. MOTHER'S MAIDEN NAME MARY ELSEA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT MR. WM. FURRY (FATHER)		Address 7324 85TH AVE. HYATTSVILLE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage & lacerations DUE TO Skull Fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Automobile accident DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Was passenger in car which failed to make curve & struck pole			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was passenger in car which failed to make curve & struck pole	
20c. TIME OF INJURY Month, Day, Year 12:40 a.m. 7/1/60 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) (County) (State) Darnestown Montg Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/5/60	
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Symond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR JUL 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

CERTIFICATE OF DEATH

Reg. Dist. No.

08147

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA - RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Bethesda (BROOKDALE)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5025-Brookdale Road</u>		d. STREET ADDRESS <u>15025-Brookdale Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles - Gallagher</u>		4. DATE OF DEATH Month Day Year <u>July 30 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Gallagher</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kelch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Lida F. Gallagher</u>		Address <u>5025 Brookdale Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u> <u>2 YEARS</u> <u>6 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:00</u> a. m. p. m. <u>7 30</u> 19 <u>60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>5/16</u> , 19 <u>60</u> , to <u>7/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/30</u> , 19 <u>60</u> , and that death occurred at <u>9:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas F. O'Connor</u>		DATE SIGNED <u>4861 BATTERY LANE</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS F. O'CONNOR</u>		<u>BETHESDA 14, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 1, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 1 '60</u>	
ADDRESS <u>2224-Wisconsin-D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

8522

NAME OF DECEASED WILLIAM J. HARRIS		AGE 65		SEX Male		RACE White		DATE OF BIRTH 1888		PLACE OF BIRTH Maryland	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath		TREATMENT Medical	
DATE OF DEATH 1953		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home		ATTENDING PHYSICIAN Dr. J. H. Smith		SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED	
DATE OF REPORT 1953		TIME OF REPORT 10:00 AM		PLACE OF REPORT Home		REPORTED BY Mrs. J. H. Harris		SIGNATURE OF REPORTER		SIGNATURE OF DECEASED	
DATE OF INTERVIEW 1953		TIME OF INTERVIEW 10:00 AM		PLACE OF INTERVIEW Home		INTERVIEWED BY Dr. J. H. Smith		SIGNATURE OF INTERVIEWER		SIGNATURE OF DECEASED	
DATE OF EXAMINATION 1953		TIME OF EXAMINATION 10:00 AM		PLACE OF EXAMINATION Home		EXAMINED BY Dr. J. H. Smith		SIGNATURE OF EXAMINER		SIGNATURE OF DECEASED	
DATE OF BURIAL 1953		TIME OF BURIAL 10:00 AM		PLACE OF BURIAL Home		BURIED BY Mrs. J. H. Harris		SIGNATURE OF BURIAL AGENT		SIGNATURE OF DECEASED	
DATE OF CREMATION 1953		TIME OF CREMATION 10:00 AM		PLACE OF CREMATION Home		CREMATED BY Mrs. J. H. Harris		SIGNATURE OF CREMATION AGENT		SIGNATURE OF DECEASED	
DATE OF AUTOPSY 1953		TIME OF AUTOPSY 10:00 AM		PLACE OF AUTOPSY Home		AUTOPSY BY Dr. J. H. Smith		SIGNATURE OF AUTOPSY AGENT		SIGNATURE OF DECEASED	
DATE OF EXHIBIT 1953		TIME OF EXHIBIT 10:00 AM		PLACE OF EXHIBIT Home		EXHIBIT BY Dr. J. H. Smith		SIGNATURE OF EXHIBIT AGENT		SIGNATURE OF DECEASED	
DATE OF RECORD 1953		TIME OF RECORD 10:00 AM		PLACE OF RECORD Home		RECORD BY Dr. J. H. Smith		SIGNATURE OF RECORD AGENT		SIGNATURE OF DECEASED	
DATE OF FINAL REPORT 1953		TIME OF FINAL REPORT 10:00 AM		PLACE OF FINAL REPORT Home		FINAL REPORT BY Dr. J. H. Smith		SIGNATURE OF FINAL REPORT AGENT		SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8138

CERTIFICATE OF DEATH

08148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakoma Park</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8510 Flower Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Donald Blount Gatling</i>		4. DATE OF DEATH <i>July 2, 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>August 18, 1899</i>
9. AGE (In years last birthday) <i>60</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attorney Federal Trade Com.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Federal Govt.</i>	
11. BIRTHPLACE (State or foreign country) <i>Forest City, Arkansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Gatling</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give way or date of service) <i>W.W.I.</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Ronald B. Gatling, Jr.</i>		Address <i>2406 Colston Ave. S.S.M.D.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerotic Heart Disease</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 1, 1960</i> to <i>July 1, 1960</i> , that I last saw the deceased alive on <i>July 1, 1960</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bennett A. Rubin</i>		M.D. <i>BENNETT A. RUBIN, M.D.</i>	
PHYSICIAN'S NAME (Type) <i>Bennett A. Rubin</i>		DATE SIGNED <i>7/2/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 6, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll St. N.W. DC</i>	
24a. REC'D BY REGISTRAR <i>Arthur S. Hume</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	
DATE <i>JUL 6 '60</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8138

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
JAMES EARL RAY		Male		35		April 4, 1968		10:00 AM		St. Louis, MO		Shot		Homicide		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Name of attending physician		17. Name of hospital		18. Name of funeral home		19. Name of cemetery		20. Name of burial place	
Attorney		High School		Single		St. Louis, MO		St. Louis, MO		[Signature]		St. Louis, MO		[Signature]		[Signature]		[Signature]	
21. Name of informant		22. Relationship		23. Address		24. Telephone		25. City		26. State		27. Zip		28. Date of birth		29. Date of death		30. Date of burial	
[Signature]		Son		[Address]		[Phone]		St. Louis		MO		63101		[Date]		[Date]		[Date]	

RAY, JAMES EARL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08149

CERTIFICATE OF DEATH

Reg. Dist. No.

8225

1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THEMY Middle S. Last GEORGI			4. DATE OF DEATH Month JULY Day 29 Year 19 60				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 31, 1891		9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR: Months 2 Days 29 Hours 19 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSIC TEACHER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dardanelles, Asia minor, Turkey		
13. FATHER'S NAME SoTirius Georgi			14. MOTHER'S MAIDEN NAME Helen Cyrmos				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT HOSPITAL RECORD		Address BETHESDA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pelvis 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of prostate DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 1 year 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. — p. m. 19 60			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 28 , 19 60 , to July 29 , 19 60 , that I last saw the deceased alive on July 28 , 19 60 , and that death occurred at 4 4 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Gilbert B. Rude M.D.			ADDRESS (Street, city or town, state) 3900 Military Rd. N.W. D.C. DATE SIGNED 7/29/60				
PHYSICIAN'S NAME (Type) Gilbert B. Rude							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF AUG. 2/60		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		22d. LOCATION (City, town, or county) (State) PRINCE GEO. CO., MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE M. W. Hyung ADDRESS 1300 N St. N.W. Washington D.C.				24a. REC'D BY REGISTRAR AUG 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

Page Two

1. NAME OF DECEASED ALBERT J. COLEMAN		2. SEX Male		3. AGE 60		4. DATE OF BIRTH 1890		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Home		14. DATE OF DEATH 1950		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF PHYSICIAN J. H. Smith		17. SIGNATURE OF REGISTRAR J. H. Smith		18. SIGNATURE OF DECEASED Albert J. Coleman		19. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith		20. SIGNATURE OF CLERK J. H. Smith	

1. NAME OF DECEASED
ALBERT J. COLEMAN
2. SEX
Male
3. AGE
60
4. DATE OF BIRTH
1890
5. PLACE OF BIRTH
Maryland
6. OCCUPATION
Carpenter
7. MARITAL STATUS
Married
8. EDUCATION
High School
9. RELIGION
Roman Catholic
10. RACE
White
11. CAUSE OF DEATH
Heart Disease
12. MANNER OF DEATH
Natural
13. PLACE OF DEATH
Home
14. DATE OF DEATH
1950
15. TIME OF DEATH
10:00 AM
16. SIGNATURE OF PHYSICIAN
J. H. Smith
17. SIGNATURE OF REGISTRAR
J. H. Smith
18. SIGNATURE OF DECEASED
Albert J. Coleman
19. SIGNATURE OF WITNESSES
J. H. Smith, J. H. Smith
20. SIGNATURE OF CLERK
J. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
8226
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08150

1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DC</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>4½ yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookgrove Foundation</u>		d. STREET ADDRESS <u>6812 Laurel St., N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Horadelle</u> First <u>Girdner</u> Middle <u>Girdner</u> Last		4. DATE OF DEATH <u>July</u> Month <u>1</u> Day <u>1960</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 5, 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Ann Muellock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>331X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u> <u>3 da</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/28/1953</u> to <u>7/1/1960</u> that (I) (we) last saw the deceased alive on <u>7/1/1960</u> and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard T Monse</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr Howard T Monse</u>		22d. ADDRESS <u>7030 Carroll Ave Tak Pk. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>July 2-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees - Wash. D. C.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 6 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

8556

CENTRAL DE DEBIT

0-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8227

CERTIFICATE OF DEATH

08151

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Iris Middle L. Last Gladhill		4. DATE OF DEATH Month July Day 22 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1909
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Lewisdale, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James B. Grimes		14. MOTHER'S MAIDEN NAME Della E. Lyddard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT William U. Gladhill, Monrovia, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, acute DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular disease DUE TO (c) many years		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe obesity; mild uremia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February , 1960, to July 22 , 1960, that I last saw the deceased alive on July 22 , 1960, and that death occurred at 12:40 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main Street DATE SIGNED			
ACTUAL SIGNATURE G. F. Meadors		M.D. Main Street	
PHYSICIAN'S NAME (Type) G. F. Meadors, M.D.		Damascus, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/60	
22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. McPherson		24a. REC'D BY REGISTRAR DATE JUL 26 '60	
24b. REGISTRAR'S SIGNATURE William E. Hume			

CERTIFICATE OF DEATH

1933



Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Date of Death		Place of Death		Cause of Death	
Occupation		Education		Marital Status	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Certificate		Place of Certificate		Signature of Deceased	
Signature of Family		Signature of Friends		Signature of Neighbors	
Signature of Clergy		Signature of Minister		Signature of Pastor	
Signature of School		Signature of Teacher		Signature of Principal	
Signature of Employer		Signature of Supervisor		Signature of Manager	
Signature of Agent		Signature of Broker		Signature of Dealer	
Signature of Officer		Signature of Sergeant		Signature of Constable	
Signature of Watchman		Signature of Patrolman		Signature of Detective	
Signature of Inspector		Signature of Assistant		Signature of Chief	
Signature of Captain		Signature of Lieutenant		Signature of Sergeant	
Signature of Corporal		Signature of Private		Signature of Soldier	
Signature of Sailor		Signature of Marine		Signature of Airman	
Signature of Merchant		Signature of Captain		Signature of Pilot	
Signature of Engineer		Signature of Mechanic		Signature of Electrician	
Signature of Carpenter		Signature of Painter		Signature of Plumber	
Signature of Blacksmith		Signature of Jeweler		Signature of Watchmaker	
Signature of Tailor		Signature of Shoemaker		Signature of Barber	
Signature of Cook		Signature of Baker		Signature of Butcher	
Signature of Farmer		Signature of Laborer		Signature of Miner	
Signature of Merchant		Signature of Captain		Signature of Pilot	
Signature of Engineer		Signature of Mechanic		Signature of Electrician	
Signature of Carpenter		Signature of Painter		Signature of Plumber	
Signature of Blacksmith		Signature of Jeweler		Signature of Watchmaker	
Signature of Tailor		Signature of Shoemaker		Signature of Barber	
Signature of Cook		Signature of Baker		Signature of Butcher	
Signature of Farmer		Signature of Laborer		Signature of Miner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8228

CERTIFICATE OF DEATH

Reg. Dist. No.

08152

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AMY KATHERINE GRADY</u>		4. DATE OF DEATH Month Day Year <u>July 15 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/88</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not employed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM METZ</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE RENECKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Same as above</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis - Degenerative</u> DUE TO (c) <u>Arteriosclerosis - Degenerative</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY</u> , 19 <u>60</u> , to <u>JULY 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JULY 15, 1960</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sam Allen</u>		ADDRESS (Street, city or town, state) <u>WASHINGTON, M.D.</u> DATE SIGNED <u>7/15/60</u>	
PHYSICIAN'S NAME (Type) <u>Sam Allen</u>			
22a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> <u>REMOVAL (Specify)</u>		22b. DATE THEREOF <u>7/18/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> ADDRESS <u>4812 Pa. Ave. NW</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 19 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1910

CERTIFICATE OF DEATH

1910

(M)

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		45		Male		White		White		Roman Catholic		Married		Farmer		Heart Disease		Home		Jan 15, 1910		10:00 AM		J. B. Smith		A. C. Jones		W. H. Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

811.5

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08153

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 29 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2024 GLEN ROSS ROAD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 2024 GLEN ROSS ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUDREY Middle SPEAKE Last GRAHAM		4. DATE OF DEATH Month JULY Day 21 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/03
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 21 Days 19 Hours 60 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDWIN RAYMOND SPEAKE	
14. MOTHER'S MAIDEN NAME LAVINIA BRAWNER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-30-1118		17. INFORMANT Mr. Daniel P. Graham, Sr. Address 2024 Glen Ross Rd. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adenocarcinoma of ovary DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1959 to July 21, 1960 that (I) (we) last saw the deceased alive on July 21, 1960 and that death occurred at 5 PM , from the causes and on the date stated above.			
22a. SIGNATURE J. Marion Bankhead		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. Marion Bankhead		22d. ADDRESS 9241 Col. Blvd. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/25/60	
23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY INC. Raymond A. Jaska		ADDRESS SILVER SPRING, MD.	
25a. REC'D BY REGISTRAR Jul 26 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

CERTIFICATE OF DEATH

Reg. Dist. No.

08154

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hos pital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle Marie Last Graham				4. DATE OF DEATH Month July Day 5 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1891	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 6 Days 16 Hours Min. 		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Gus Wisener				14. MOTHER'S MAIDEN NAME Ella Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 577-05-2053			
17. INFORMANT Neil Graham-Husband-				Address 5315 Glenwood Road Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute Congestive Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension Heart Disease DUE TO (c) 							
INTERVAL BETWEEN ONSET AND DEATH 24 HRS 5 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 7, 1960 to July 5, 1960 , that I last saw the deceased alive on July 5, 1960 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo I Donovan M.D.				ADDRESS (Street, city or town, state) 8218 Wisconsin Ave Bethesda 14 MD.			
DATE SIGNED 7/5/60							
PHYSICIAN'S NAME (Type) LEO I DONOVAN MD				BETHESDA 14 MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/8/60		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
22d. LOCATION (City, town, or county) Washington, D. C.				(State) 			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland			
24a. REC'D BY REGISTRAR JUL 7 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
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CERTIFICATE OF DEATH

IN THE STATE OF NEW YORK

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

CERTIFICATE OF DEATH

Reg. Dist. No.

08155

8230

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>15049 Bradley Blvd.</i>	
3. NAME OF DECEASED (Type or print) <i>UNNAMED</i> First <i>Infant Boy</i> Middle <i>Grant.</i> Last <i>Grant.</i>		4. DATE OF DEATH <i>July 26</i> 19 <i>60</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26, 1960</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <i>11</i> MONTHS <i>11</i> DAYS <i>11</i> HOURS <i>11</i> MIN.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Mont. Co. Md.</i>	
13. FATHER'S NAME <i>Raymond Earl Grant</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		14. MOTHER'S MAIDEN NAME <i>Willie Ann Rander.</i>	
16. SOCIAL SECURITY NO. <i>769-1</i>		INFORMANT <i>St's. Chart.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure, undetermined Cause</i> DUE TO <i>769-1</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>769-1</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Maternal diabetes</i>			INTERVAL BETWEEN ONSET AND DEATH <i>11 hours</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7/26</i> , 19 <i>60</i> , to <i>7/26</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>7/26</i> , 19 <i>60</i> , and that death occurred at <i>7:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John E. Cassidy</i>		ADDRESS (Street, city or town, state) <i>9911 Georgetown Rd. Bethesda</i>	
PHYSICIAN'S NAME (Type) <i>JOHN E. CASSIDY</i>		DATE SIGNED <i>7/26/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>7/29/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L. CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey, Inc.</i> ADDRESS <i>Silver Spring Md.</i>		24a. REC'D BY REGISTRAR <i>JUL 29 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove paraffin papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8231

08156

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 10 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wheaton Nursing Home		d. STREET ADDRESS 1 106 Lynch Street	
3. NAME OF DECEASED (Type or print) First Israel Middle B. Last Grossman		4. DATE OF DEATH Month 7 Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocery store	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Grossman		14. MOTHER'S MAIDEN NAME Dora	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant cachexia DUE TO (b) Metastatic Carcinoma of Liver DUE TO (c) Carcinoma of Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 26, 1956 , to JULY 16, 1960 , that (I) (we) last saw the deceased alive on JULY 15, 1960 , and that death occurred at 5:10 A.M., from the causes and on the date stated above.			
22a. SIGNATURE Robert G. Angle		22b. DATE SIGNED July 1960	
22c. PHYSICIAN'S NAME (Type) Robert G. Angle		22d. ADDRESS 5009 Del Ray Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 17/60	
23c. NAME OF CEMETERY OR CREMATORY Anshe Eimurah		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Sol Lowenstein		25a. REC'D BY REGISTRAR DATE JUL 18 '60	
ADDRESS 6000 Cent. Rd.		25b. REGISTRAR'S SIGNATURE Arthur S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8232

CERTIFICATE OF DEATH

08157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>D. O. A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Richard</u> Middle <u>Gue</u> Last				4. DATE OF DEATH <u>July</u> Month <u>26</u> Day <u>60</u> Year <u>19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 3, 1882</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. AGE (In years last birthday) <u>78</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			
13. FATHER'S NAME <u>James H. Gue</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. Edna Gue</u>				Address <u>Rt. #2 Gaithersburg</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, Acute Coronary</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>55</u> , to <u>7-26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-12</u> , 19 <u>60</u> , and that death occurred at <u>5:45</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>7-27-60</u> ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Jack Schumacher</u> <u>Gaithersburg, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>		22d. LOCATION (City, town, or county) (State) <u>Etchison, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>				ADDRESS <u>aytonsville, Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>JUL 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8233

CERTIFICATE OF DEATH

08158

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>11543 - N. Falkland Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Gumme</u> Last <u>L</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 18, 1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward G. Gumme</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Kiefert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes-unknown</u>		INFORMANT <u>Frances Pearl Gumme</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>5:40 P.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 13, 1960</u> to <u>19 July, 1960</u> that I last saw the deceased alive on <u>19 July, 1960</u> and that death occurred at <u>5:40 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Horace W. Burnton</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10511 Summit Ave Rockville, Md 7/19/60</u>					
PHYSICIAN'S NAME (Type) <u>Horace W. Burnton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Murphy</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>Jul 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneal</u>			

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CERTIFICATE OF DEATH

STATE OF NEW YORK

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08159

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D. C.</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington, Maryland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanitarium</i>		d. STREET ADDRESS <i>4440 Burlington Place N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>Emma</i>		4. DATE OF DEATH <i>July 19, 1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 30, 1868</i>
9. AGE (In years last birthday) <i>92</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Voorhes</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Frank</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Ethel H. Ashman same as #2D</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar pneumonia</i> <i>490x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Septicemia</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 da.</i> <i>2 da.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>gentl arteriosclerosis, Mesenteric thrombosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 19, 1960</i> to <i>July 19, 1960</i> , that (I) (we) last saw the deceased alive on <i>July 19, 1960</i> , and that death occurred at <i>7:45</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Sjogren</i>		22b. DATE SIGNED <i>7-19-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert W. SJOGREN</i>		22d. ADDRESS <i>1835 Eye St. N.W., Washington, D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>11/11/11</i>		23b. DATE THEREOF <i>7/22/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Maple Ave. Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Fultonville, N. Y.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>S. H. Hines</i>		25a. REC'D BY REGISTRAR <i>DATE JUL 21 '60</i>	
ADDRESS <i>C.O. 2901 14th St. N.W., Wash, D.C.</i>		25b. REGISTRAR'S SIGNATURE <i>William S. Hines</i>	

CERTIFICATE OF DEATH

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THE STATE
DEPARTMENT
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AMERICAN COMMITTEE'S CERTIFICATE OF STAIN

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DATE 11, 1900, OFFICE OF THE SECRETARY OF THE AMERICAN COMMITTEE

10-10-19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8173

CERTIFICATE OF DEATH

Reg. Dist. No. 08161

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM				d. STREET ADDRESS 3219 Macomb Street N. W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MARY		First		Middle E		Last HARDIE	
4. DATE OF DEATH JULY 4		Month		Day		Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 24 76		9. AGE (In years last birthday) 84	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ISSAC KLINE				14. MOTHER'S MAIDEN NAME MARY EYRE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT HELEN WINFIELD		Address 3219 MACOMB ST NW Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia, right, acute DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Embolism from left heart DUE TO (c) Auricular fibrillation							INTERVAL BETWEEN ONSET AND DEATH 16 hrs. 16 hrs. 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general advanced							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Jan 29 , 19 59 , to July 4 , 19 60 , that I last saw the deceased alive on July 4 , 19 60 , and that death occurred at 8:40 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stewart Clapp				M.D. 4740 Chevy Chase Dr.		DATE SIGNED 7-5-60	
PHYSICIAN'S NAME (Type) Stewart Clapp M.D. Chevy Chase, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/60		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company				ADDRESS 2901 14 ST NW WASHINGTON D.C.		24a. RECEIVED BY REGISTRAR JUL 6 '60	
				24b. REGISTRAR'S SIGNATURE William S. Hines		24c. REGISTRAR'S SIGNATURE William S. Hines	

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CERTIFICATE OF DEATH

1913

WATKINS, E. O.

MONTGOMERY

Washington

NEW YORK

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NEW YORK

WATKINS

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WATKINS

WATKINS

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8234

08162

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>12 Da.</u>				d. STREET ADDRESS <u>19220 Kingsbury Dr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Dorothea</u> Middle <u>Ohl</u> Last <u>Hardy</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucas</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 25, 1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min.		IF UNDER 24 HRS. Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>			
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>			
13. FATHER'S NAME <u>Hibert Ohl</u>				14. MOTHER'S MAIDEN NAME <u>Dorothea Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hibert & Hardy</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO (b) <u>Hypertensive and arteriosclerotic heart disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>443X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>known 3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour <u>o. m.</u> p. m. <u>p. m.</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1</u> 19 <u>57</u> , to <u>July 27</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>July 24</u> 19 <u>60</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Aaron H. Traum</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 27 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>				22d. ADDRESS <u>8237 Ga. Ave., Silver Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		23b. DATE THEREOF <u>7/29/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ohltown Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Trouble County, Ohio</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	
DATE <u>AUG 1 '60</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08163

8235

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Be the sda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in 1b <u>3 days 3 hrs</u>		d. STREET ADDRESS <u>1804 Lanzerk Way</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>E.</u> Middle <u>Glendon</u> Last <u>Harmon</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1912</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motor Vehicle Parts</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Hubert H. Harmon</u>		14. MOTHER'S MAIDEN NAME <u>Schmidt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>232-10-0173</u>	
INFORMANT <u>Marie B. Harmon</u> Address <u>5400 Rte 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction Posterior wall, left ventricle</u> 420.1 DUE TO <u>Thrombosis, Posterior Coronary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Coronary Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ORGANOMEGALY, OBESITY, DIABETES MELLITUS</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10</u> , 19 <u>60</u> , to <u>July 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>60</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Angle</u>		ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave., Bethesda, Md.</u> DATE SIGNED <u>7/12/60</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		<u>5009 Del Ray Ave., Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 15 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kras</u>	

RECEIVED
FEB 14 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

8233

[Faint, mostly illegible text from a death certificate form, including fields for name, date of birth, date of death, and cause of death.]

[Signature]

Robert G. Smith
1000 Walnut Ave., New York, N.Y.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08164

Reg. Dist. No.

8163

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>97 Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>104 Tulip Dr.</u>				d. STREET ADDRESS <u>1104 Tulip Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Loretta Bowen Hartley</u>				4. DATE OF DEATH Month Day Year <u>July 6 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-26-91</u>	
9. AGE in years last birthday <u>68</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Thomas A. Bowen</u>				14. MOTHER'S MAIDEN NAME <u>Susan Gardick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Dorothy Nelson</u>				Address <u>Stem 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Coronary Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)							
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>9 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brochert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROCHERT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8 July 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Nelson</u>				ADDRESS <u>Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 8 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

DATE SIGNED

7-7-60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

8140

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sant Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Hartung Carl (NMN) Hartung Jr.</i>		4. DATE OF DEATH Month Day Year <i>7 15 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>11-3-83</i>
9. AGE (In years last birthday) yrs. <i>76</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Paint & Hardware</i>	
11. BIRTHPLACE (State or foreign country) <i>District of Columbia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Carl Hartung Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Wilhelmina Wrenzt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>Hospital Rec'ds</i>	
17. INFORMANT <i>Hospital Rec'ds</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hem. & Hemiplegia (1st 7/10/60 - 2nd 7/13/60)</i> DUE TO (b) <i>Rt. Broncho pneumonia</i> DUE TO (c) <i>Suicide attempt (Chloroform)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7/13/60</i> <i>7/10/60</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/28/1954</i> to <i>7/13/60</i> , that I last saw the deceased alive on <i>7/13/60</i> , and that death occurred at <i>3:10 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>7020 Carroll Ave</i> DATE SIGNED <i>7/15/60</i>			
ACTUAL SIGNATURE <i>Howard T. Morse</i> M.D.		PHYSICIAN'S NAME (Type) <i>Howard T. Morse M.D. Takoma Park, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>July 18, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Geo. Co. Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i>		24. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	
24a. REC'D BY REGISTRAR DATE <i>JUL 19 60</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

8236

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08166

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Evelyn Middle M Last HATFIELD		4. DATE OF DEATH Month July Day 7 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-13
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest NOENNICH		14. MOTHER'S MAIDEN NAME Edith NOTTOFF	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 days Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - 3 years +			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the hospital attended the deceased from July 1, 19 60 to July 7, 19 60 , that (I) the last saw the deceased alive on July 7, 19 60 , and that death occurred at 1:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE F. S. Caldwell		22b. DATE SIGNED 7-8-60	
22c. PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-11-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		25a. REC'D BY REGISTRAR Jul 12 '60	
ADDRESS W.W. Chambers Funeral Home, 5801 Cleveland Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

82-10

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Decemur (name) 6 days
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may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
8141
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08167

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwyn Heights 1668-2</u> d. STREET ADDRESS <u>6012 Quebec St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William John Heffernan</u>				4. DATE OF DEATH Month Day Year <u>July 18 1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-5-16</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouse Mgr.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Matthew Heffernan</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Louis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW-2 071-01-3384</u>		17. INFORMANT <u>PT's Chart</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <u>Massive Cerebral Hemorrhage</u> DUE TO <u>460x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of liver</u> DUE TO (c) <u>Bleeding Esophageal Varices</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 year</u> <u>2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic alcoholism & arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>July 1945</u> to <u>7-18 1960</u> , that (I) (we) lost the deceased alive on <u>7-18-1960</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>N.C. Shoemaker MD</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>N.C. SHOEMAKER, MD</u>				22d. ADDRESS <u>8005 Woodbury Dr. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-22-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Co Riverdale Md</u> ADDRESS				25a. REC'D BY REGISTRAR <u>JUL 26 1960</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8237 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08168

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 24 hrs 20 min s. 32	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS 4408- Great Oak Rd. -Manor Club	
3. NAME OF DECEASED (Type or print) Charles Howard Lockwood Hines		4. DATE OF DEATH July 26 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1954
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Mont. Co.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME C. Calvert Hines Jr.		14. MOTHER'S MAIDEN NAME Janet Stanley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Pt's Chart		Address ---	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Contusion 8/13 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 24 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. ---		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Rode bike in front of car - laceration of jaw - unconscious	
20c. TIME OF INJURY Month, Day, Year 6:00 p.m. 7/25 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Rockville		20g. (County) Montg	
20h. (State) Md.		20i. (City or town) Rockville	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John G. Ball		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 26 July 60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-28-60	
22c. NAME OF CEMETERY OR CREMATORY St. John's Episcopal		22d. LOCATION (City, town, or county) (State) Olney, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR ---		24b. REGISTRAR'S SIGNATURE Charles L. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
8116																			
CERTIFICATE OF DEATH																			
Reg. Dist. No. 08169																			
1. PLACE OF DEATH o. COUNTY <u>Montgomery Co. MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>1921 KALOPOLIS RD N.W.</u> b. COUNTY <u>WASHINGTON DC</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. LENGTH OF STAY IN 1b <u>6 mo</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON DC</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althea Woodland N.H.</u>					d. STREET ADDRESS <u>9301 Weaver St</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Mary CASSEL Holloway</u>					4. DATE OF DEATH <u>7 13 1960</u>														
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-21-1881</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>					11. BIRTHPLACE (State or foreign country) <u>PA.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				
13. FATHER'S NAME <u>Henry Burd Cassel</u>					14. MOTHER'S MAIDEN NAME <u>Mary Ann Patterson</u>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>NONE</u>					INFORMANT <u>Mrs. H. C. Torbert, SAME AS # 2</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia (terminal)</u> <u>491X</u> <u>DOCTOR</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>ununioned hip fracture</u> DUE TO (c) <u>-----</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>10 mos</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>48</u> , to <u>7-13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-11</u> , 19 <u>60</u> , and that death occurred at <u>1:38</u> M, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <u>1835 Eye St NW Wash DC</u>					DATE SIGNED				
ACTUAL SIGNATURE <u>Hill Carter</u>					M.D. <u>1835 Eye St NW Wash DC</u>														
PHYSICIAN'S NAME (Type) <u>HILL CARTER</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>7/16/60</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Marietta Cemetery</u>					22d. LOCATION (City, town, or county) (State) <u>MARIETTA, PENNSYLVANIA</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudin</u>					ADDRESS <u>1756 PA. AVE., N.W., D. C.</u>					24a. REC'D BY REGISTRAR <u>JUL 14 '60</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon in Part I. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8238
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08170

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Norbeck		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Philomena Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12,609-Atherton-Drive Silver Spring	
f. STREET ADDRESS 12,609 Atherton Drive		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eugene Middle Joseph Last Hourihane SR.		4. DATE OF DEATH Month July Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 17, 1997
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S.Govt.-Navy Dept.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene J. Hourihane, Sr.		14. MOTHER'S MAIDEN NAME Sarah Mullen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Gertrude M. Hourihane, 12,609 Atherton Dr.		Address S. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH one hour 5 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1956 to July 10, 1960 , that (I) (we) last saw the deceased alive on July 6, 1960 and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE HARRY J. KICHERER		22b. DATE SIGNED July 10, 1960	
22c. PHYSICIAN'S NAME (Type) HARRY J. KICHERER		22d. ADDRESS 5527 Surry St., Chevy Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 13, 1960	
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		25a. REC'D BY REGISTRAR DATE JUL 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08171

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN lb Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Reddix Res., Fairland Rd.							
3. NAME OF DECEASED (Type or print) Linwood Jackson		First Middle Last		4. DATE OF DEATH July 2, 1960		Day Month Year	
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/1938		9. AGE (In years last birthday) 22	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Benjamin Jackson				14. MOTHER'S MAIDEN NAME Grace Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Ernest Jackson (uncle)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination DUE TO (b) Exsanguination of heart & aorta DUE TO (c) Gunshot wounds of thorax PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) shot in chest- accused unknown				INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) shot in chest- accused unknown					
20c. TIME OF INJURY Month, Day, Year 1:30 a.m. 7/2/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Silver Spring Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 7/2/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/60		22c. NAME OF CEMETERY OR CREMATORY Good Hope.,		22d. LOCATION (City, town, or country) (State) Colesville, Md.	
23. FUNERAL DIRECTOR Robert L. Snodder				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

HEALTH UNIT



2117

Management

Silver Spring

Redox Inc., Raleigh, N.C.

Blindfold

Journal

on

6/14/1938

22

July 7, 1940

USA

Benjamin Jackson

James Jackson

1241, Raleigh, N.C.

James Jackson (uncle)

Silver Spring, Md.

and in case of accident

1:30 - 1:45

Silver Spring, Md.

1:30

Frank J. Proctor

Raleigh, N.C.

Redox Inc.

1241, Raleigh, N.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
8239											
CERTIFICATE OF DEATH											
Reg. Dist. No. 08172											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>57</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>2310 KANSAS AVE</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>JOHNSON</u>					4. DATE OF DEATH Month <u>JULY</u> Day <u>5</u> Year <u>1960</u>						
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLOR</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 5 1960</u>		9. AGE (In years lost birthday) <u>—</u> yrs. <u>—</u> months <u>—</u> days <u>—</u> hours <u>—</u> min. <u>55</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>PAUL JOHNSON</u>					14. MOTHER'S MAIDEN NAME <u>DOROTHY ELIZABETH REDDIX</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>MOTHER</u>			Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Atelectasis</u> DUE TO <u>742.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Immaturity</u> (c) <u>Prematurity</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1hr</u> <u>1hr</u> <u>1hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>JULY 5, 1960</u> to <u>JULY 5, 1960</u> , that I last saw the deceased alive on <u>JULY 5, 1960</u> , and that death occurred at <u>4:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>78-60 DATE SIGNED</u>											
ACTUAL SIGNATURE <u>Francis J. Troendle</u>			M.D. <u>809 Viers Mill Rd Rockville Md</u>								
PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>			<u>809 Viers Mill Road Rockville, Md.</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>			22b. DATE THEREOF <u>7-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>			22d. LOCATION (City, town, or county) (State) <u>8600 O'Neale Road Bethesda Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital 8600 O'Neale Road Bethesda Md.</u>			ADDRESS <u>Bethesda</u>			24a. REC'D BY REGISTRAR <u>Jul 12 '60</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>		

2074 285 XV0

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

Blank form area for the Certificate of Death, containing faint horizontal lines for text entry.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please secure the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8182 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08173

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>1/2 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southlawn Home</u>				d. STREET ADDRESS <u>1 Avery Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type of print) <u>Florence Johnson</u>				4. DATE OF DEATH <u>July 31 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1888</u>	
9. AGE (in years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Augustus Williams</u>				14. MOTHER'S MAIDEN NAME <u>Ida Botts</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lorenzo Johnson</u>		Address <u>Southlawn Home Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> (c) <u>hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschardt</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>7-31-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8-4-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>		22d. LOCATION (City, town, or county) (State) <u>Norbeck, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>			
				24a. REC'D BY REGISTRAR <u>AUG 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

MEDICAL CERTIFICATION

2

August 11, 1918
Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. H. [Signature]

South Louisiana
Baton Rouge, La.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8240

08174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD #1 Germantown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD #1 Germantown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Maurice</u> Middle <u>O.</u> Last <u>Johnson, Sr.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1911</u>
9. AGE (In years lost birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles W. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Nettie L. Hungerford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>21214 1711</u>	
INFORMANT <u>Dorothy Repp</u> Address <u>Rt. #2 Union Bridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/12/59</u> to <u>7/14</u> , 19 <u>60</u> that I last saw the deceased alive on <u>7/16/60</u> , 19 <u> </u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Kerr</u> M.D.		ADDRESS (Street, city or town, state) <u>Damascus, Md.</u> DATE SIGNED <u>7/19/60</u>	
PHYSICIAN'S NAME (Type) <u>Dr. James P. Kerr</u>		<u>Damascus, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-16-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Grove, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 19 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneass</u>	

CERTIFICATE OF DEATH

0530



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8118 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08175											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Woodburn Farm - Layhill Rd</u>						d. STREET ADDRESS <u>3310 Randolph Rd</u>					
3. NAME OF DECEASED (Type or print) <u>JOHN William</u>						First		Middle		Last	
4. DATE OF DEATH <u>July 18 1960</u>						Month		Day		Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-18-1945</u>		9. AGE (In years last birthday) <u>15</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student - Belt Jr. High School</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Williamsport, Pennsylvania</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>John William Johnson, Sr.</u>						14. MOTHER'S MAIDEN NAME <u>Marion Annabelle Orso</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>none</u>					
17. INFORMANT <u>Mr. John Wm. Johnson, Sr.,</u>						Address <u>3310 Randolph Rd. Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>drowning</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned in pond while swimming</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>2:15</u> p.m. <u>7-18</u> 19 <u>60</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) <u>Silver Spring Montg Md</u> (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschack</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschack</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						22b. DATE THEREOF <u>7/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR <u>WARNER E. DUMPHREY, INC.</u>						ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

8118

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

State of New York
County of New York
City of New York
I, the undersigned, a duly qualified Medical Examiner, do hereby certify that on the 1st day of July, 1920, at New York City, New York, I examined the body of
John William Johnson, deceased,
and found that he died of
Heart Disease,
and that the death was caused by
Natural Causes.

Witness my hand and the seal of my office this 1st day of July, 1920.
John William Johnson, M.D.,
Medical Examiner.

Attest:
I, John W. Johnson, Esq., City Clerk,
do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the files of the City of New York.

Witness my hand and the seal of my office this 1st day of July, 1920.
John W. Johnson, Esq.,
City Clerk.

ASSISTANT MEDICAL EXAMINER, AUSTIN, VIRGIL A.

FILED JUL 15 1920

Medical Examiner notified and approved

<div> <div>8119</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</div> </div> <div>08176</div> </div>											
<div> <div>CERTIFICATE OF DEATH</div> <div>Item 16 Film 62-8-8-60 et</div> </div>											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4510 Mahan Road				d. STREET ADDRESS 4510 Mahan Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle KALASSAY Last KALASSAY				4. DATE OF DEATH July Month 29 Day 1960 Year							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1896		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Kalassay Alexander				14. MOTHER'S MAIDEN NAME Elizabeth Abatazy							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 578-30-5952		17. INFORMANT Address Getha Kalassay, 4510 Mahan Rd., S.S., Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 A.C. Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Coronary Artery Disease DUE TO (c) Generalized Atherosclerosis										INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1950 to July 27, 1960 , that (I) (we) last saw the deceased alive on July 6, 1960 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.											
22a. SIGNATURE Bernard Katzen				22b. DATE SIGNED 7-22-60				22c. PHYSICIAN'S NAME (Type) BERNARD KATZEN M.D.			
22d. ADDRESS 3250 MICHIGAN AVE. S.E. WASH.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation				23b. DATE THEREOF 7/30/1960		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Shuler's Sons				ADDRESS Washington, D. C.				25a. REC'D BY REGISTRAR DATE AUG 2 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

8119

CERTIFICATE OF DEATH

State of New York
County of Albany
City of Albany
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 10th day of July, 1924, at Albany, New York, I attended the deceased, *John J. [illegible]*, who died at the residence of the deceased, *John J. [illegible]*, at the age of *45* years, of the disease of *Myocarditis*, the result of *hypertension*, and that the deceased was not suffering from any contagious or infectious disease at the time of death, and that the death was not caused by any violence, fraud, or other unlawful means, and that the death was the result of natural causes.

Witness my hand and the seal of my office this 10th day of July, 1924, at Albany, New York.
[Signature]
Physician
My commission expires on the 10th day of July, 1925.
Attest:
I, the undersigned, a duly qualified and licensed physician, do hereby certify that the above is a true and correct copy of the original certificate of death filed in my office on the 10th day of July, 1924, at Albany, New York.
[Signature]
Physician
My commission expires on the 10th day of July, 1925.

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

8241
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 108177

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8600 Brickyard Rd</u>				d. STREET ADDRESS <u>8600 Brickyard Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Paul Jay Kasloff</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-17-1914</u>	
9. AGE (in years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Kasloff</u>				14. MOTHER'S MAIDEN NAME <u>Rose</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mary Kasloff -</u> Address <u>Stun 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO <u> </u> (e), stating the underlying cause last. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7-2-60</u>							
ACTUAL SIGNATURE <u>Frank J. Broschalt</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschalt</u>		Address (Street, city, town, or county) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 5, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden</u>		22d. LOCATION (City, town, or country) (State) <u>Falls Church, Virginia</u>	
23. FUNERAL DIRECTOR <u>B. Danzansky & Sons</u> ADDRESS <u>WASH, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
6241

FOR STATE
HEALTH DEPT



[Faint, mostly illegible handwritten text follows, likely containing patient information, cause of death, and examiner details.]



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

8183 8178
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 220 N. Washington St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 220 N. Washington St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles D. Kelly		First Middle Last		4. DATE OF DEATH July 11, 1960		Month Day Year	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10/1905	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Construct. Ind.		11. BIRTHPLACE (State or foreign country) Charlottesville, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Kelly				14. MOTHER'S MAIDEN NAME Emma E. Taylor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) World War # 2		16. SOCIAL SECURITY NO. ?		17. INFORMANT Mrs. Emma Hollins Address 807 West St., Charlottesville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Found dead in bed.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/11/60	
EXAMINER'S NAME (Type) Frank J. Broschart				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13, 1960		22c. NAME OF CEMETERY OR CREMATORY Oakwood cemetery.,		22d. LOCATION (City, town, or country) (State) Charlottesville, Va.	
23. FUNERAL DIRECTOR Robert L. Sullivan ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE JUL 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8242

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08179

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Henry Last KELSON		4. DATE OF DEATH Month July Day 4 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negroid	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-84
9. AGE (In years lost birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver	11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James KELSON	
14. MOTHER'S MAIDEN NAME Sarah BARBARA		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. (W) Mrs. Margaret Key Kelson, same as #2 above		17. INFORMANT (W) Mrs. Margaret Key Kelson, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 18 days 3 yrs 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from June 15 19 60 to July 4 19 60 , that (I) (we) last saw the deceased alive on July 4 19 60 , and that death occurred at 7:45 M, from the causes and on the date stated above.		22a. SIGNATURE John Wood Davis M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 7-4-60	
22c. PHYSICIAN'S NAME (Type) JOHN WOOD DAVIS LT MC USN		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-8-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE McGuire Funeral Home		25a. REC'D BY REGISTRAR DATE JUL 6 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		26. ADDRESS McGuire Funeral Home, 1820 9th St., NW, WashDC	

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W. C. Sullivan

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8243
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Film G267 7-26-60 et
CERTIFICATE OF DEATH

Reg. Dist. No. 08180

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson		c. LENGTH OF STAY IN 1b 1 yr		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private Home				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Rebecca Last Kessler		4. DATE OF DEATH Month July Day 8 Year 19 60		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 4-1889		9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife-----own home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry L. Clements				14. MOTHER'S MAIDEN NAME Nellie M. Nicholson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Thomas Kessler, Dickerson, Md		17. INFORMANT Thomas Kessler, Dickerson, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 6 days 1 year 1 year		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3, 1960 , to July 8, 1960 , that I last saw the deceased alive on July 7, 1960 , and that death occurred at 8:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Vernon E. Martens M.D.				ADDRESS (Street, city or town, state) Barnesville, Md			
PHYSICIAN'S NAME (Type) Vernon E. Martens				DATE SIGNED July 8-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/70		22c. NAME OF CEMETERY OR CREMATORY St Marys		22d. LOCATION (City, town, or county) (State) Barnesville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton				ADDRESS Barnesville, Md		24a. REC'D BY REGISTRAR DATE JUL 13 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

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Journal of Interpersonal Violence 26(10)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8142
CERTIFICATE OF DEATH

Reg. Dist. No.

08181

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park d. STREET ADDRESS 900 Kennebec Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Linda Middle Hyun-Sook Last Kim		4. DATE OF DEATH Month July Day 28 Year 19 60	
5. SEX Female	6. COLOR OR RACE Brown	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1960
9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR Months 7 Days 7 Hours 10 Min. 10	IF UNDER 24 HRS. Months 7 Days 7 Hours 10 Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Gun Hyuk Kim		14. MOTHER'S MAIDEN NAME Kung-Hie Lyu	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Gun Hyuk Kim		Address 900 Kennebec Ave., TP, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 21 , 19 60 , to July 28 , 19 60 , that I last saw the deceased alive on July 28 , 19 60 , and that death occurred at 9:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Emma Hughes		ADDRESS (Street, city or town, state) 7600 Carroll Ave., Tak. Pk., Md. DATE SIGNED 8-7-60	
PHYSICIAN'S NAME (Type) Emma Hughes, M.D.		ADDRESS 7600 Carroll Ave., Takoma Park, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-2-60	
22c. NAME OF CEMETERY OR CREMATORY Wash. San. & Hospital		22d. LOCATION (City, town, or county) (State) Takoma Park Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robt. A. Hare, M.D.		ADDRESS 7600 Carroll Ave., TP, Md.	
24a. RECEIVED BY REGISTRAR 10 80		24b. REGISTRAR'S SIGNATURE Robert A. Hare	

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in no event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8143 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08182

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN b 3 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7700 TAKOMA AVENUE				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 18 TAKOMA PARK d. STREET ADDRESS 7700 TAKOMA AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEONARD First Middle Last		4. DATE OF DEATH JULY 24 19 60 Month Day Year		5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 11/8/13 9. AGE (In years last birthday) 46 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Installed awnings 10b. KIND OF BUSINESS OR INDUSTRY Awnings Harry Thomas Co. 11. BIRTHPLACE (State or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George T. King 14. MOTHER'S MAIDEN NAME Susan Clementson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WW #2 16. SOCIAL SECURITY NO. yes 17. INFORMANT Mrs. Martha M. Johnson, 4501 Ill. Ave., N.W. Washington, D.C. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/24/60 Address (Street, city, town, or county) ACTUAL SIGNATURE John S. Ball M.D. EXAMINER'S NAME (Type) JOHN G. BALL 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 7/27/60 22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY 22d. LOCATION (City, town, or country) (State) PRINCE GEO. COUNTY, MARYLAND 23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD. 24a. REC'D BY REGISTRAR DATE JUL 28 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

15212

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8120

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08183

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>134 RITCHIE AVE.</u>		d. STREET ADDRESS <u>134 RITCHIE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUTH</u> <u>JEAN KLIMASZEWSKI</u>		4. DATE OF DEATH Month Day Year <u>JULY</u> <u>27</u> <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 29, 1927</u>
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANK CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANK</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLINTON SKYRE</u>		14. MOTHER'S MAIDEN NAME <u>JULIA WEAVER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>EDWARD KLIMASZEWSKI, 134 RITCHIE AVE. SPRING, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Air Embolism</u> DUE TO <u>Entry of air into venous circulation thru uterine wall from partially separated placenta.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cause: to be determined. (deceased pregnant with twins, about 12 to 13 weeks gestation)</u> (c) <u>twins, about 12 to 13 weeks gestation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SILVER SPRING, MD.</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) <u>John G. Ball.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/27/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>AUGUST 1, 1960</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>DALLAS, LUZERNE CO., PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Ball</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

8244

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08184

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Trailer Camp Rt#1 Box 17D Bryans Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle KNAPP Last KNAPP				4. DATE OF DEATH Month July Day 23 Year 1960			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1960		9. AGE (In years last birthday) yrs. 6	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Dallas Leslie KNAPP				14. MOTHER'S MAIDEN NAME Barbara Louise HAMMOND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father		Address (See #2 Above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) Neonatal Atelectosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 762.5 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 22 1960 to 23 July 1960 , that (I) (we) last saw the deceased alive on July 23 1960 , and that death occurred at 2:30 AM on the causes and on the date stated above.							
22a. SIGNATURE Fred W. GRELO LT MC USN				22b. DATE SIGNED 7-23-60		22c. PHYSICIAN'S NAME (Type) Fred W. GRELO	
22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-26-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUL 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

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8334

CERTIFICATE OF DEATH

05124

U. S. Naval Medical
Hospital (1001)

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8144

08185

1. PLACE OF DEATH a. COUNTY <i>Montgomery Md.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lakoma Park</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>54 Chevy Chase</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Jan & Hosp</i>				d. STREET ADDRESS <i>1441 Elm St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FRANK</i> First <i>Charles</i> Middle <i>KRACEK</i> Last				4. DATE OF DEATH Month <i>7</i> Day <i>5</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-16-90</i>	9. AGE (In years lost birthday) <i>69</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Govt</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Physicist</i>		11. BIRTHPLACE (State or foreign country) <i>Czechoslovakia</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Matthew Kracek</i>				14. MOTHER'S MAIDEN NAME <i>Mary Marchan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>p.t. Hosp record.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163X</i> DUE TO <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Metastatic Carcinoma</i> DUE TO (c) <i>Carcinoma of the Lung.</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 mos?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>July 2, 1960</i> to <i>July 5, 1960</i> , that (I) (we) lost the deceased alive on <i>July 5, 1960</i> , and that death occurred at <i>5:15</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert A. Hare</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED <i>7/5/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert A. Hare MD</i>				22d. ADDRESS <i>7600 Carroll Ave. T.P.K. Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>7/8/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>				ADDRESS <i>Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>JUL 8 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

BP

CERTIFICATE OF DEATH

8144



MADE IN U.S.A.

Item 14 Filing 267 7-21-60 et MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8121

CERTIFICATE OF DEATH

08186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>29</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9201 Coleville Road</i>				d. STREET ADDRESS <i>9201 Coleville Road</i>			
3. NAME OF DECEASED (Type or print) First <i>OLIVE</i> Middle <i>BLANCHE</i> Last <i>KREUZBURG</i>				4. DATE OF DEATH Month <i>July</i> Day <i>13</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 1, 1877</i>	
9. AGE In years last birthday <i>82</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS.		11. BIRTHPLACE (State or foreign country) <i>Cincinnati, Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Restaurant Owner</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Food</i>			
13. FATHER'S NAME <i>Will Morgan</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Richard J. Kreuzburg</i>		Address <i>3713 Cardigan Rd. Ch. Ch.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive Heart Failure</i> DUE TO (b) <i>arteriosclerotic Heart Disease</i> DUE TO (c) <i>arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1952</i> to <i>July 13, 1960</i> , that I last saw the deceased alive on <i>July 12, 1960</i> , and that death occurred at <i>4 4 M</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Marcel J. Foret</i> M.D.				ADDRESS (Street, city or town, state) <i>1746 K St N.W.</i>		DATE SIGNED <i>7/13/60</i>	
PHYSICIAN'S NAME (Type) <i>MARCEL J. FORET</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 18, 1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Spring Grove Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Cincinnati, Ohio.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i>				ADDRESS <i>254 Carroll St NW DC</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 18 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kneet</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11517

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
AGE
SEX
MARRIAGE
OCCUPATION
CAUSE OF DEATH
PLACE OF BIRTH
DATE OF BIRTH
MOTHER'S NAME
FATHER'S NAME
MARRIAGE DATE
MARRIAGE PLACE
MARRIAGE OFFICER
MARRIAGE WITNESSES
MARRIAGE VOUCHER
MARRIAGE CERTIFICATE
MARRIAGE RECORD
MARRIAGE INDEX
MARRIAGE FILE
MARRIAGE BOOK
MARRIAGE CARD
MARRIAGE ENTRY
MARRIAGE LIST
MARRIAGE SUMMARY
MARRIAGE TOTAL
MARRIAGE PERCENTAGE
MARRIAGE AVERAGE
MARRIAGE STANDARD
MARRIAGE DEVIATION
MARRIAGE COEFFICIENT
MARRIAGE CORRELATION
MARRIAGE REGRESSION
MARRIAGE INTERCORRELATION
MARRIAGE MULTICORRELATION
MARRIAGE PARTIAL CORRELATION
MARRIAGE SEMI-PARTIAL CORRELATION
MARRIAGE STEPWISE CORRELATION
MARRIAGE CANONICAL CORRELATION
MARRIAGE PRINCIPAL COMPONENTS
MARRIAGE FACTOR ANALYSIS
MARRIAGE DISCRIMINANT ANALYSIS
MARRIAGE CLUSTER ANALYSIS
MARRIAGE PRINCIPAL COMPONENTS
MARRIAGE FACTOR ANALYSIS
MARRIAGE DISCRIMINANT ANALYSIS
MARRIAGE CLUSTER ANALYSIS

8245

CERTIFICATE OF DEATH

Reg. Dist. No.

08187

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1702 Willoughby St. Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Zephier</u> First Middle Last <u>LaBrie</u>		4. DATE OF DEATH <u>July 1</u> Month Day Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-30-88</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Circulation</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>news paper.</u>	
11. BIRTHPLACE (State or foreign country) <u>S. DAKOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur LaBrie</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Victoria LeFort</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>48605-4407</u>	
17. INFORMANT <u>Willetta M. Coe</u> Address <u>Rockville, 702 Willoughby</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO <u>Pulmonary Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Fibrosis</u> DUE TO (c) <u>under</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 yrs</u> <u>undetermined</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/1/60</u> to <u>7/1/60</u> , that I last saw the deceased alive on <u>7/1/60</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville, Md</u> DATE SIGNED <u>7/1/60</u>	
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		<u>Rockville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>7/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>
22d. LOCATION (City, town, or county) <u>Kansas City, Kansas</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>1331 E. Montgomery Avenue Rockville, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 6 '60</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1924

1. Name of deceased: John Doe
2. Sex: Male
3. Age: 45
4. Date of death: Jan 15 1924
5. Place of death: Home
6. Cause of death: Heart Disease
7. Signature of physician: Dr. J. H. Smith
8. Signature of registrar: John Doe
9. Signature of informant: John Doe
10. Date of registration: Jan 15 1924

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8122

CERTIFICATE OF DEATH

08189

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Kennedy-Warren b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.		c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Althea Woodland N.H.				d. STREET ADDRESS 3133 Conn. Ave. N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle F. Lanham Last				4. DATE OF DEATH Month July Day 24 Year 19 60			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17-1876	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D of C		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Isaiah Fearing				14. MOTHER'S MAIDEN NAME Henrietta Grandy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Washington, DC Renah F. Camalier 5001 Van Ness St. NW			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 1 week (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma left breast (postoperative status)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1960 to July 24, 1960 that I last saw the deceased alive on July 23, 1960 and that death occurred at 5:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) W.K. Billingsley Jr. M.D. 1835 - 6th St. N.W. 7-24-60 DATE SIGNED ACTUAL SIGNATURE W.K. Billingsley Jr. PHYSICIAN'S NAME (Type) WILLIAM K. BILLINGSLEY JR. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				24a. REC'D BY REGISTRAR DATE JUL 26 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

818

(M)

W. H. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

8246

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08190

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 27 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Teaneck c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 362 Balsam Street d. STREET ADDRESS 67X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Vivian (None) LaRose			4. DATE OF DEATH Month Day Year July 24 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1930		9. AGE (In years last birthday) 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey	
13. FATHER'S NAME Victor Ippolito		14. MOTHER'S MAIDEN NAME Marianni Zica			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Acute Myelogenous Leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 1 Day 6 Months					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) July 24		20g. (County) Bergen County		20h. (State) New Jersey	
21. I certify that (I) (this hospital) attended the deceased from June 27 19 60 , to July 24 19 60 , that (I) (we) last saw the deceased alive on July 24 19 60 , and that death occurred at 4:25pm , from the causes and on the date stated above.					
22a. SIGNATURE Richard E. Rieselbach, M.D.		22b. DATE SIGNED 7-25-60		22c. PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 7-25-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	
23d. LOCATION (City, town, or county) Bergen County		23e. (State) New Jersey		23f. REC'D BY REGISTRAR JUL 27 '60	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kruza	

1512

8247

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08191

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4833 West Lane			d. STREET ADDRESS 4833 West Lane		
3. NAME OF DECEASED (Type or print) First Marjorie Middle Benton Last Lee			4. DATE OF DEATH Month July Day 13 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1877		9. AGE (In years lost birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New Hampshire	
12. CITIZEN OF WHAT COUNTRY? US			13. FATHER'S NAME Charles Benton		
14. MOTHER'S MAIDEN NAME Elizabeth Barker			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Address Madeline Benton-neice-same 2d		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 2 years					INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Rectum - 2 years					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 28, 1959 to July 13, 1960 , that (I) (we) last saw the deceased alive on July 13, 1960 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.					
22a. SIGNATURE Neil P. Campbell		22b. DATE SIGNED July 13, 1960		22c. PHYSICIAN'S NAME (Type) Neil P. Campbell	
22d. ADDRESS 3060 - 16th St. W. 4		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/16/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d. LOCATION (City, town, or county) Suitland, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JUL 15 '60	
25b. REGISTRAR'S SIGNATURE C. L. S. Knecht					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8247

CERTIFICATE OF DEATH

Montgomery

Married

Montgomery

Bedford

Bedford

4835 West Lane

4835 West Lane

Married

Bedford

Lee

13

Female White

Jan. 20, 1977

13

Montgomery

Van De Walle

13

Charles Bedford

Elizabeth Snyder

None

Bedford

Consent of the Father and Mother

Attest: I, _____, Clerk of the Court, do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Court.

Witness my hand and the seal of the Court at _____, this _____ day of _____, 1977.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, '18

8123

CERTIFICATE OF DEATH

Reg. Dist. No.

08192

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 6 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle REBECCA Last Lindner		4. DATE OF DEATH Month July Day 31 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1884
9. AGE (In years lost birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles H. Atz		14. MOTHER'S MAIDEN NAME Barbara Ellen Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Multiple Cerebral Thromboses		INTERVAL BETWEEN ONSET AND DEATH 72 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20, 1960 to Jul 31, 1960 that I last saw the deceased alive on Jul 31, 1960 and that death occurred at 4:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert T. Thibadeau		ADDRESS (Street, city or town, state) 10609 CONCORD ST.	
PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU		DATE SIGNED Jul 31	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/2/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co Md. 1960	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		ADDRESS Washington, D. C.	
24a. REC'D BY REGISTRAR AUG 2 '60		24b. REGISTRAR'S SIGNATURE Clinton S. Frank	

8153

CERTIFICATE OF DEATH

Montgomery

Silver Spring

5 yrs

Indian Road

Green Meadows Court

Green Meadows Court

July

Washington, D. C.

Washington, D. C.

Robert E. Green

Robert E. Green

Green Meadows Court

none

Green Meadows Court

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

8248 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

08193

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ellen Middle Sidney Last Lockhart		4. DATE OF DEATH Month July Day 31 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/82
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Homemaker - own home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Algernon Lockhart		14. MOTHER'S MAIDEN NAME Mary Evelyn Longacre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Leafy Cleaves		Address 9904 Capital View Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus Ulcer		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days 3 weeks 20 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3:15 p.m. 31 July 1960 to 7:30 a.m. 1 Aug 1960 , that I last saw the deceased alive on 31 July 1960 , and that death occurred at Suburban Hospital from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Murphy		DATE SIGNED 1 Aug 1960	
PHYSICIAN'S NAME (Type) WILLIAM MURPHY		M.D. W. Murphy	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/3/60	
22c. NAME OF CEMETERY OR CREMATORY MT. HEBRON CEMETERY		22d. LOCATION (City, town, or county) (State) WINCHESTER, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR Aug 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8145

18194

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 Silver Spring</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sanitarium + Hosp.</u>			d. STREET ADDRESS <u>18830 Sudbury Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Carrie GERTRUDE Lucas</u>			4. DATE OF DEATH <u>7 - 28 1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/85</u>		9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Henry Hawes</u>			14. MOTHER'S MAIDEN NAME <u>Florence Hawes</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hosp. Records - Washington San. & Hosp.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4-20-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>7-28</u> , 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>July 27 1960</u> , and that death occurred at <u>2 P.</u> M., from the causes and on the date stated above.					
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>7-28-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>217 University Blvd E., H Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/1/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>PRINCE GEO. COUNTY, MARYLAND</u>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Humphrey, Inc.</u>		ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>AUG 3 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>					

8145

NAME: *John J. Murphy*
AGE: *21* YEARS
SEX: *Male*
RACE: *White*
DATE OF BIRTH: *Aug 15 1900*
PLACE OF BIRTH: *New York City*
OCCUPATION: *Student*

CAUSE OF DEATH: *Heart Disease*
DISEASE OR INJURY: *Myocardial Infarction*
PERIOD OF ILLNESS: *One Week*
PLACE OF DEATH: *Home*
MANNER OF DEATH: *Natural*
SIGNATURE OF PHYSICIAN: *Dr. J. J. Murphy*

DATE OF DEATH: *Aug 22 1921*
TIME OF DEATH: *10:30 AM*
PLACE OF DEATH: *Home*
MANNER OF DEATH: *Natural*
SIGNATURE OF PHYSICIAN: *Dr. J. J. Murphy*
SIGNATURE OF REGISTRAR: *John J. Murphy*
OFFICE OF THE REGISTRAR: *New York City*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G268 8-9-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

08188

8184

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>315 Lincoln Ave.,</u>				d. STREET ADDRESS <u>315 Lincoln Ave.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AMANDA</u> Middle <u>V.</u> Last <u>LUCKETT</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>19 60</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 13, 1874</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Peter Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Martha ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. _____			
17. INFORMANT <u>William G. Luckett</u>				Address <u>Lincoln Ave., Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>C.S.CVD & Hypertension</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>2/1/1956</u> , to <u>7/25/1960</u> that I last saw the deceased alive on <u>7/25/1960</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen R. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>7/28/60</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snodden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 2 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name

Rank

Service No.

Date of Death

Place

Cause

Signature

Witness

Remarks

Signature

Witness

Remarks

Signature

Witness

Remarks

Signature

Witness

Remarks

Signature

Witness

Remarks

8124

CERTIFICATE OF DEATH

08195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home				d. STREET ADDRESS 11505 Schuylkill Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Roger W. Lusby sr.				4. DATE OF DEATH Month July Day 4 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb./6/1884	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Drugs		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard H. Lusby				14. MOTHER'S MAIDEN NAME Georgiana Standbury			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-12-9539		INFORMANT Address Roger W. Lusby, jr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerosis, Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Small Cerebral Vascular Occlusions DUE TO (c) Multiple Small Cerebral Vascular Occlusions							INTERVAL BETWEEN ONSET AND DEATH 1 Hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1959 to July 4 1960 , that I last saw the deceased alive on July 2 1960 , and that death occurred at 4:50p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert T. Thibadeau M.D.		ADDRESS (Street, city or town, state) 10609 Concord Street Kensington, Maryland					
DATE July 4-1960		DATE SIGNED					
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J W LEE 300 47 ST NW DC				24a. REC'D BY REGISTRAR DATE JUL 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

316

2010 12 15

8164

Item 1 Film G267 7-21-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 08196

1. PLACE OF DEATH a. COUNTY Montg MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 11 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 40 Summit Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Paul Last Lynch				4. DATE OF DEATH Month July Day 11 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July** Apr 22-1896.64	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months 2 Days 19	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Manager Federal Reserve Board				10b. KIND OF BUSINESS OR INDUSTRY Washington.D.C.			
11. BIRTHPLACE (State or foreign country) U S A				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Michael J. Lynch				14. MOTHER'S MAIDEN NAME Ida Owens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 				16. SOCIAL SECURITY NO. 			
17. INFORMANT Constance B. Lynch. Gaithersburg. Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, Acute 4-20-0 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 				20f. (City or town) (County) (State) 			
21. I certify that I attended the deceased from May 15, 1960 to July 11, 1960 that I last saw the deceased alive on July 11, 1960 , and that death occurred at 8 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Schumacher M.D.				ADDRESS (Street, city or town, state) 105 Russell Ave. 7-13-60			
PHYSICIAN'S NAME (Type) Jack Schumacher M.D. Gaithersburg, Md.				DATE SIGNED 			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14-60		22c. NAME OF CEMETERY OR CREMATORY Neelsville.		22d. LOCATION (City, town, or county) (State) Germantown. Rural. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.				24a. REC'D BY REGISTRAR JUL 18 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

8164

George

Californian

11/11

Californian

Maryland

North

40 Summit Ave

James

Paul

John

July

11

20

Miss Anne

X

origin for 22-1884-4

19

Travis Manner Federal Reserve Bank Washington, D.C.

U.S.A.

Michael J. Smith

Los Angeles

40 Summit Ave

Benjamin E. Lynch, Californian, Md.

Harley

July 10-20 Nashville

Washington, D.C.

Ernest C. Campbell, Californian, Md.

11/11

1*
FOR STATE HEALTH DEPT.
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2
TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5426 Wisconsin Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5426 Wisconsin Avenue d. STREET ADDRESS 5426 Wisconsin Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH A. LYNCH		4. DATE OF DEATH Month July Day 26 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Manager		10b. KIND OF BUSINESS OR INDUSTRY Chevy Chase Land Co.	9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months 19 Days 19 IF UNDER 24 HRS. Hours 19 Min. 19
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Lynch		14. MOTHER'S MAIDEN NAME Jane McCarthy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 183-03-4992	
17. INFORMANT Leo W. Lynch.		18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1 DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (b) few min. (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John W. Ball		DATE SIGNED 26 July 60	
EXAMINER'S NAME (Type) John W. Ball		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-29-1960	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or country) Philadelphia, Pa.	
23. FUNERAL DIRECTOR Joseph Gaudier's Sons, Inc. Wash. D.C.		24. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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RECEIVED JUL 10 1964

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1
FOR STATE
HEALTH DEPT.

TO NOTIFY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

8249
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
08198

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Hts</u>		c. LENGTH OF STAY IN lb <u>1 day</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6432 Wiscasset Hts</u>				d. STREET ADDRESS <u>19006 Buxedette Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anthony William March Jr</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-43</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Anthony Wm March</u>				14. MOTHER'S MAIDEN NAME <u>Margorie Walker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>A.W. March (father)</u>		Address <u>Stn 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Contusion and lacerations</u> DUE TO (b) <u>Multiple fractures of skull</u> DUE TO (c) <u>Gunshot wound</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>	
2Da. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally shot with 32 cal. rifle</u>					
20c. TIME OF INJURY Month, Day, Year <u>5:20 p.m. 7-10 1960</u>		2Dd. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Glen Echo Hts. montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Boschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BOSCHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>7-11-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 12 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

Robert A. Campbell, Secretary, National Association of Manufacturers, Washington, D.C.

April 12, 1930

Dear Sir:

I have your letter of April 10, 1930, regarding the proposed

amendment to the National Labor Relations Act, and in reply

to inform you that the National Association of Manufacturers

has no objection to the proposed amendment.

Very truly yours,

Robert A. Campbell

Secretary

National Association of Manufacturers

Washington, D.C.

Enclosed for you are two copies of the proposed amendment

to the National Labor Relations Act.

Very truly yours,

Robert A. Campbell

Secretary

National Association of Manufacturers

Washington, D.C.

April 12, 1930

8250

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08199

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>City Wheaton</u>				c. LENGTH OF STAY IN 1b <u>1 yr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WHEATON NURSING Home</u>				d. STREET ADDRESS <u>2205 42nd ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Moore</u> Last <u>Marshall</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>CAUC.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/26/1885</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R. NURSE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>—</u>							
13. FATHER'S NAME <u>George Thomas Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Emma Rogers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Gladys B. Marshall</u> Address <u>2205-42nd St. NW Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Cerebral Thrombosis</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Cerebral Arterio-Sclerosis</u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>10/15/59</u> to <u>7/20/60</u> , that (I) (we) last saw the deceased alive on <u>7/19/60</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>E. Stuart Lyddane</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>E. Stuart Lyddane M.D.</u>				22d. ADDRESS <u>3066 Que Street N.W., Washington D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7/20/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Williamsville, Va - Marshall Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sanders Sons, 1756 Pa. Ave. NW D.C.</u>				25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>JUL 21 '60</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

85710

CERTIFICATE OF DEATH

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[Faint, mostly illegible text, likely a form for a death certificate. Some words are difficult to decipher but appear to include:]

Full name of deceased: [illegible]
Age: [illegible]
Sex: [illegible]
Date of birth: [illegible]
Place of birth: [illegible]
Occupation: [illegible]
Marital status: [illegible]
Signature of [illegible]: [illegible]
Date: [illegible]



1900 and 1901

[Faint signature or stamp at the bottom left.]

1900

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8251

8251

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08200

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JESSIE BELLE MARSHALL				4. DATE OF DEATH Month Day Year JULY 3 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/90		9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry				10b. KIND OF BUSINESS OR INDUSTRY Cam. Laundry		11. BIRTHPLACE (State or foreign country) TENN.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME KAYO SMITH				14. MOTHER'S MAIDEN NAME MARY HIGGINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 408 14 6997		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchial Asthma & Congestive Failure DUE TO (c) Chronic Myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) INTERVAL BETWEEN ONSET AND DEATH 15 min 2 wks. yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 50 to 7/3 19 60 , that (I) (we) lost saw the deceased alive on 7/3 19 60 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
22a. SIGNATURE [Signature] M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 7/4/60							
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D. 22d. ADDRESS SANDY SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 6 1960			
23c. NAME OF CEMETERY OR CREMATORY Laytonsville				23d. LOCATION (City, town, or county) (State) Laytonsville Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Francis X Barber				25a. REC'D BY REGISTRAR DATE JUL 7 '60			
ADDRESS Laytonsville, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8252

08291

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 44 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timmons ville 77X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Rt. 2, Box 212		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alton Middle Durwood Last MATTHEWS		4. DATE OF DEATH Month July Day 25 Year 19 60					
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-04	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY U.S.Navy		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Toy S. Matthews				14. MOTHER'S MAIDEN NAME Laura Morris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 247-16-5444		17. INFORMANT Address (D) Mrs. Carolyn Thompson, Rt.5, Darlington, S.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanoma, Malignant 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 7 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8:55 p. m. 7/25/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 11 1960 to July 25 1960 , that (I) (we) last saw the deceased alive on July 25 1960 , and that death occurred at 8:55 AM , from the causes and on the date stated above.							
22a. SIGNATURE Robert C. Thomas				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-25-60	
22c. PHYSICIAN'S NAME (Type) R. C. THOMAS, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-26-60		23c. NAME OF CEMETERY OR CREMATORY Cartersville Cemetery		23d. LOCATION (City, town, or county) (State) Cartersville South Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUL 28 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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CERTIFICATE OF DEATH

8532

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1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]
12. Place of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8253

CERTIFICATE OF DEATH

08202

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>42 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltoville</u>		<u>1674.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resner Hospt. and Sanitarium</u>				d. STREET ADDRESS <u>11525 Montgomery Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Abbie</u> Middle <u>F.</u> Last <u>May</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1876</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John King</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Eugene May, same as 2d</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Common Acute Stomach Toxemia</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Chronic Pyelonephritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 yr.</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio sclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-11-60</u> , 19 <u>60</u> , to <u>7-10-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 10</u> , 19 <u>60</u> , and that death occurred at <u>5 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>915-19th St. N.W. Wash. D.C.</u> DATE SIGNED <u>7/11/60</u>							
ACTUAL SIGNATURE <u>Maurice Protas</u> M.D.				PHYSICIAN'S NAME (Type) <u>Maurice Protas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 12, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				ADDRESS <u>Rivendale, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	
24c. REC'D BY REGISTRAR DATE <u>JUL 12 '60</u>							

8254

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase 27</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp</u>		d. STREET ADDRESS <u>8218-Larry Pl.</u>	
3. NAME OF DECEASED (Type or print) <u>James Marshall Mayes</u>		4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/14/1897</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Commerce Tenn.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Walter Marshall Mayes</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes World War II</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mary B. Mayes</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>same</u> DUE TO (c) <u>same</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June, 1955</u> , to <u>July 27, 1960</u> , that I last saw the deceased alive on <u>7-27-60</u> , 19 <u>60</u> , and that death occurred at <u>4:28 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph A. Bailey</u> M.D.		ADDRESS (Street, city or town, state) <u>Washington Clinic, Western Ave & Wis. Ave. NW, Wash., D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Joseph A. Bailey</u>		DATE SIGNED <u>7-27-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 1, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Co., Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>		ADDRESS <u>3072 - M St. NW, Wash., D.C.</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		DATE <u>AUG 2 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text and stamps are visible across the form. A large, faint "M.D." stamp is prominent in the center. The form appears to be a standard death certificate with fields for personal information, cause of death, and medical history.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8185

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08204

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 310 Nimitz Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle M. Last Mayhew		4. DATE OF DEATH Month July Day 6 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1928
9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		12. KIND OF BUSINESS OR INDUSTRY Restaurant	
13. FATHER'S NAME Rufus Cornwell, Sr.		14. MOTHER'S MAIDEN NAME Hattie V. Cummings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes-Unknown	
17. INFORMANT Amos W. Mayhew-Husband-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 322.0 DUE TO acute alcoholism with 1) acidosis 2) cirrhosis liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 weeks 6 mo		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 30, 1960 to July 6, 1960 that (I) (we) last saw the deceased alive on July 5, 1960 , and that death occurred at 7 AM , from the causes and on the date stated above.			
22a. SIGNATURE Patrick C. Jameison		22b. DATE SIGNED 7/6/60	
22c. PHYSICIAN'S NAME (Type) Patrick C. Jameison		22d. ADDRESS 12020 Georgia Ave. Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/9/60	
23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town, or county) (State) Leesburg, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus		DATE JUL 8 '60	

8125

OFFICE OF DEATH

Montgomery

Montgomery

Montgomery

Rockville

Rockville

San Antonio

San Antonio

Martha V. Thompson

Yes - I know of the death of the person named

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8255

08205

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY McDowell	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Fork	
c. LENGTH OF STAY IN 1b 1 day		d. STREET ADDRESS Box 444	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle James Last McColl		4. DATE OF DEATH Month July Day 1 Year 19 60	
5. SEX Male	6. COLOR OR RACE cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28 1960
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ira N McColl		14. MOTHER'S MAIDEN NAME Carol Jean Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Tracheoesophageal fistula Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. and prematurity DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days 4 days 4 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 30 6:05 to July 1 , 19 60 that (I) (we) last saw the deceased alive on July 1 , 19 60 , and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C. A. Broadus Jr. CDR MC USN		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Shipments		23b. DATE THEREOF 7-3-60	
23c. NAME OF CEMETERY OR CREMATORY McDowell Co.		23d. LOCATION (City, town, or county) (State) W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> R. A. Humphrey Funeral Home		25a. REC'D BY REGISTRAR JUL 6 '60	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25c. ADDRESS Bethesda, Md.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
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CERTIFICATE OF DEATH

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VR A15 (4)
15M 9/59

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8256

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

Item 3 Film 267 7-22-60 et

CERTIFICATE OF DEATH

08206

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 2 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 15 Barnacle Green, S. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle MC GOWAN Last MC GOWAN		4. DATE OF DEATH Month July Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-60
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2	
11. IF UNDER 24 HRS. Hours 15			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene E. MC GOWAN		14. MOTHER'S MAIDEN NAME Madeline Pearl MARQUIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Eugene E. McGowan, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal Asphyxia DUE TO Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity (c) Immaturity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) postmortem attended the deceased from Birth to July 18, 1960 , that (I) was last saw the deceased alive on July 18, 1960 , and that death occurred at 1:10 PM , from the causes and on the date stated above.			
22a. SIGNATURE Fred W. Grello		22b. DATE 7-18-60	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 7-19-60	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Worthington Minnesota	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		25a. REC'D BY REGISTRAR DATE JUL 20 '60	
25b. REGISTRAR'S SIGNATURE Charles L. Hume			

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CERTIFICATE OF DEATH

Reg. Dist. No. 08207

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Meixell Last Meixell		4. DATE OF DEATH Month July Day 29 Year 19 60	
5. SEX Msle	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 11 Days 6 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Ephrath, Penn.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry J. Meixell		14. MOTHER'S MAIDEN NAME Strohl, Emma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Ruth F. Meixell (Wife)		Address As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Cerebral arteriosclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? (c) ?		INTERVAL BETWEEN ONSET AND DEATH 7 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 5, 1959 to July 29, 1960 that I last saw the deceased alive on July 29, 1960 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George A. Gray, Jr.		ADDRESS (Street, city or town, state) 4740 Chevy Chase Drive, Md.	
PHYSICIAN'S NAME (Type) George A. GRAY, JR., M.D.		DATE SIGNED 7/29/60	
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF August 1, 1960	
22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR AUG 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert A. Thompson, Baltimore, Maryland

Robert A. Thompson, Baltimore, Maryland

Rockville, Maryland

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8258

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08208

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5200 Chamberlin Avenue		d. STREET ADDRESS 5200-Chamberlin Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph H. Milans		4. DATE OF DEATH Month Day Year July 12 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Patent Attorney		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph D. Milans		14. MOTHER'S MAIDEN NAME Lillian McPhearson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Gertrude B. Milans		Address 5200 Chamberlin Ave. Kenwood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia from Ruptured Pulmonary Artery 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized Arteriosclerosis DUE TO (c) 10 years INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Hemiplegia of 12 years duration			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 15 1948 to July 12 1960 , that (I) (we) last saw the deceased alive on Jan 10 1960 , and that death occurred at 4:45 M, from the causes and on the date stated above.			
22a. SIGNATURE Thomas S. Sappington M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas S. Sappington		22d. ADDRESS 1025 Conn. Ave N.W. Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/14/60	
23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		25a. REC'D BY REGISTRAR DATE JUL 13 '60	
25b. REGISTRAR'S SIGNATURE Charles E. Hines			

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[illegible]

11/10/00

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CONCLUSIONS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VP A15 (4)
15M 9/59

1
8259
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08209

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miles Rd Burtonsville c. LENGTH OF STAY IN 1b 14 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2910 - Miles Rd				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 Burtonsville d. STREET ADDRESS Miles Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Rose Caroline		First Caroline Middle Miles Last Miles		4. DATE OF DEATH Month July Day 14 Year 1960			
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 11, 1875		9. AGE (In years lost birthday) 84 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Howard Co. Md.			
13. FATHER'S NAME MARTIN Luther Iager		14. MOTHER'S MAIDEN NAME MARY Smith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT ANNE MOSHER - 2910 - Miles Rd Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Pneumonia DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Vascular disease DUE TO (c) Urinary Infection				INTERVAL BETWEEN ONSET AND DEATH 20 hrs years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary Infection				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 12-20 1959 to 7-14 1960 that (I) (we) last saw the deceased alive on 7-13 1960 and that death occurred at 5:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Roy B. Parsons Jr MD		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) ROY B. PARSONS JR MD		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 17, 1960		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery			
23d. LOCATION (City, town, or county) Burtonsville Md		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE DeWitt Caralston, Land, Md		ADDRESS		25a. REC'D BY REGISTRAR JUL 20 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Hume							

IN RE: [illegible] and [illegible]

vs. [illegible]

[illegible]

[illegible]

[illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08210

8260

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 14 Yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4948 Battery Lane				d. STREET ADDRESS 14948 Battery Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NELLIE Middle TREMMELL Last MILLER				4. DATE OF DEATH Month JULY Day 5 , Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1885	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Month 11 Days 19		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Frank Tremmell				14. MOTHER'S MAIDEN NAME Margaret MacDonald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Fred H. Miller, Jr. Address MT. Vernon, New York			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Found dead sitting in chair at home.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		July 6, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 7/9/60		22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		22d. LOCATION (City, town, or county) (State) Coxsackie, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 7 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

8165
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

08211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) Asbury Methodist Home		d. STREET ADDRESS Formerly of 17 Newburg Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Maggie Rosella Molesworth		4. DATE OF DEATH July 26th 1960.	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 18, 1878	
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		12. BIRTHPLACE (State or foreign country) Illinois	
13. FATHER'S NAME Rufus Molesworth		14. MOTHER'S MAIDEN NAME Elizabeth Wiggins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Asbury Methodist Home-Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) central vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NAILED FRACTURE OF RT hip		INTERVAL BETWEEN ONSET AND DEATH 7-23-60	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-4 , 19 56 , to 7-26 , 19 60 , that I last saw the deceased alive on 7-23 , 19 60 , and that death occurred at 8:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah E. Glover		ADDRESS (Street, city or town, state) 10128 CEDAR LAVE KENSINGTON, MD	
DATE SIGNED 7-26-60			
PHYSICIAN'S NAME (Type) Sarah E. Glover, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/60	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Rickner ADDRESS Balto - 17 Md.		24a. REC'D BY REGISTRAR JUL 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

John S. Ball - M. D. - Deputizing Med. Examiner Md. 090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove retention papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

8261

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6269 8-22-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

08212

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 4 1/2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland D. C. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Washington d. STREET ADDRESS 3415 Ashley Terrace, N. W. Waverly Sanitarium e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First M eta Middle W Last Mooney		4. DATE OF DEATH Month July Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, '80
9. AGE (In years last birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Bruce West	
14. MOTHER'S MAIDEN NAME Addie (?)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		INFORMANT G. Bruce West (Nephew) Address 6105 Welborn Drive, Beth.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Thrombosis of Rt. mid cerebral artery INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1954 to 25 July 1960 , that I last saw the deceased alive on 25 July 1960 , and that death occurred at 1:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert M. Martyn Jr. M.D.		ADDRESS (Street, city or town, state) 5029 Bethesda Ave DATE SIGNED 26 July 60	
PHYSICIAN'S NAME (Type) HERBERT MARTYN JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/60	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington, D. C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 28 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

REFERENCES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8262

CERTIFICATE OF DEATH

Reg. Dist. No.

08213

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. Gen. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Etchison	
f. STREET ADDRESS RFD # 2, Gaithersburg		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle F. Last Moore		4. DATE OF DEATH Month July Day 10 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1881
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Etchison, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Moore		14. MOTHER'S MAIDEN NAME Lydia Warfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-2414	
17. INFORMANT Mrs Pearl E. Moore, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 10, 1947 to July 10, 1960 that I last saw the deceased alive on July 9, 1960 , and that death occurred at 2:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Damascus, Md.	
PHYSICIAN'S NAME (Type) James P. Kerr		DATE SIGNED 7/11/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/12/60	
22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth		24a. REC'D BY REGISTRAR DATE JUL 13 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. House			

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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• 54 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9-59

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Page 1

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8263

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 412 37th Street, S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Anthony Last MORALES				4. DATE OF DEATH Month July Day 25 Year 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-24-60	
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry MORALES				14. MOTHER'S MAIDEN NAME Betty Jo BITTLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline Membrane Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 773.3 (c) Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from July 24 8:15 PM to July 25 19 60 , that (I) xxx last saw the deceased alive on July 25 19 60 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Fred W Grello				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-26-60	
22c. PHYSICIAN'S NAME (Type) FRED W. GRELO, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-29-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUL 28 '60	
				25b. REGISTRAR'S SIGNATURE C. L. H. H. H.			

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8263

CERTIFICATE OF DEATH

MAINTAINED BY DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS

1102

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		35		Jan 1, 1900		New York, N.Y.	
Cause of Death		Occupation		Marital Status		Date of Death		Place of Death	
Heart Disease		Teacher		Married		Jan 15, 1935		New York, N.Y.	
Physician		Buried or Interred		Name of Burial Place		Date of Burial		Place of Burial	
Dr. J. Smith		Yes		St. John's Church		Jan 20, 1935		New York, N.Y.	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Issued by		Title		Signature		Seal	
Jan 20, 1935		[Signature]		Registrar		[Signature]		[Seal]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8146

08215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				d. STREET ADDRESS <u>9912 Indian Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. CAUSE OF DEATH (Type or print) <u>Alcohol</u> First <u>Mercer</u> Middle <u>Morrey</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-11-92</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock room mgr.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Solstrand Co</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>John B. Morrey</u>				14. MOTHER'S MAIDEN NAME <u>Helen Mercer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>577-10-7093</u>		17. INFORMANT <u>PH Hosp record.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebellar Hemorrhage</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with extension into Pons</u> (c) <u>Hypertensive Cardiac Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 6, 1949</u> to <u>July 24, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 24, 1960</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip E. Jones</u> M.D.				22b. DATE <u>7/24/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>	
				22d. ADDRESS <u>918 Ellsworth Drive Silver Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 28, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 29 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

8148

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS AND STATISTICS
STATE OF NEW YORK

1921

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8125

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>19 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1009 Merrimac Dr. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Franklin</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 15, 1897</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Apt. house</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Stephen Morris</u>				14. MOTHER'S MAIDEN NAME <u>Frederick Quinton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>231-32-0888</u>		17. INFORMANT <u>Home Morris</u> Address <u>1009 Merrimac Dr. Silver Spring Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Previous Coronary Occlusion</u> DUE TO <u>3 1/2 mo.</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 30, 1960</u> to <u>July 25, 1960</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>July 18, 1960</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James H. White M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-25-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>James H. White</u>				22d. ADDRESS <u>776 Carroll Ave Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL <u>Removal</u>		23b. DATE THEREOF <u>7/26/60</u>		23c. NAME OF FUNERAL HOME <u>WAPLES FUNERAL HOME</u>		23d. LOCATION (City, town, or county) <u>CAMDEN, N.J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rabert A. Shorrock</u>				25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneal</u>	
25c. DATE <u>JUL 27 '60</u>				25d. ADDRESS <u>—</u>			

CERTIFICATE OF DEATH

812

NO. 1000000000

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100

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

8264

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.				d. STREET ADDRESS 4000 Cathederal Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Winifred S. Morrow				4. DATE OF DEATH Month July Day 16 Year 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/25/85		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clinton Smith				14. MOTHER'S MAIDEN NAME WEITHEA Coleman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hosp. Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 hrs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7-18-1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawrence Sons 1756 R. Ave. Wash. D.C.				24a. REC'D BY REGISTRAR JUL 19 '60		24b. REGISTRAR'S SIGNATURE Charles S. Evans	

DATE SIGNED
7/16/60

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8147
 CERTIFICATE OF DEATH

08218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pri. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>hand over</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven, 517 Albany Ave</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Edmonia</u> Last <u>Nalley</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Joseph Nalley</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Hill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Edward Nalley, Rt. Landover Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>434.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Longstanding heart failure - atherosclerosis</u> DUE TO <u>Fibillation probably due Rheumatic heart disease</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>0</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>60</u> to <u>July 6</u> , 19 <u>60</u> that I last saw the deceased alive on <u>July 5</u> , 19 <u>60</u> , and that death occurred at <u>2550</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H Wolbom</u>				DATE SIGNED <u>7401 Blair Rd NW Wash DC</u>			
PHYSICIAN'S NAME (Type) <u>Chas H Wolbom</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1880</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
11. SIGNATURE OF REGISTRAR <i>John Doe</i>		12. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>	
13. SIGNATURE OF CLERK <i>John Doe</i>		14. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>	
15. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		16. SIGNATURE OF CLERK <i>John Doe</i>	
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08219

8148

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. SAN. and Hosp.</u>				d. STREET ADDRESS <u>2701 14th St., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Lee</u> Newberry				4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1960</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-1-92</u>			
				9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Attorney</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Frank H. Treadwell</u>				14. MOTHER'S MAIDEN NAME <u>Emily Earle</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Hospital Records --</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-vascular disease</u> DUE TO (c) <u>?</u>								INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bleeding Cushing Duodenal ulcer & anemia</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1960</u> to <u>July 29, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 29, 1960</u> , and that death occurred at <u>6:15 M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert A. Hare</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>7-30-60</u>					
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>				22d. ADDRESS <u>809 Davis Ave, Takoma Pk, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>7/31/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elian Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Melrose, Florida</u>			
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. S. H. Hays Co 2901-14th St. N.W. D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 2, '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08220

8126

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 5 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2627 Wissman Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Isabelle B. Nicholson		4. DATE OF DEATH Month July Day 4 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7 1893
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 7 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Burris		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Reuben Nicholson		Address 431 N. Frederick Ave Gaithersburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 DUE TO Coronary artery insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic heart disease with (c) chronic heart failure INTERVAL BETWEEN ONSET AND DEATH 7 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 3 1959 to July 4 1960 that (I) (we) last saw the deceased alive on June 17 1960 , and that death occurred at 2:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Adam H. Traum		22b. DATE SIGNED July 6 1960	
22c. PHYSICIAN'S NAME (Type) Adam H. Traum		22d. ADDRESS 8237 Georgia Ave, Silver Spring Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 6 1960	
23c. NAME OF CEMETERY OR CREMATORY Brookeville		23d. LOCATION (City, town, or county) (State) Brokeville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis X. Barber		ADDRESS Laytonville, Md.	
25a. REC'D BY REGISTRAR Jul 11 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

CERTIFICATE OF DEATH

8128



DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Age

Sex

Occupation

Usual Residence

Place of Birth

Marital Status

Education

Religion

Service in Armed Forces

Signature of Registrar

Signature of Physician

Signature of Coroner

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
8265
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08221

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia <input checked="" type="checkbox"/> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Qtrs. 20678, Marine Corps Schools			
3. NAME OF DECEASED (Type or print) First Bessie Middle Clay Last OAKLEY				4. DATE OF DEATH Month July Day 13 Year 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-96	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David COZART				14. MOTHER'S MAIDEN NAME Kallie SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 240-44-1304		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular fibrillation DUE TO (c) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 20 min. years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Squamous cell carcinoma, cervix uteri, stage IV							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) deceased attended the deceased from July 5, 1960 to July 13, 1960 that (I) was last saw the deceased alive on July 13, 1960 , and that death occurred at 3:30AM , from the causes and on the date stated above.							
22a. SIGNATURE R. F. MADING				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-13-60	
22c. PHYSICIAN'S NAME (Type) R. F. MADING, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-16-60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Boyd Funeral Home				25a. REC'D BY REGISTRAR DATE JUL 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1588

CERTIFICATE OF DEATH

8305

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

NAME: [Illegible]
DATE: [Illegible]
LOCATION: [Illegible]
CAUSE OF DEATH: [Illegible]
CERTIFICATE NO.: [Illegible]

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

2

3

8149
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08222

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakeoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
c. LENGTH OF STAY IN 1b <u>DOA-19</u>				d. STREET ADDRESS <u>Greencastle Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San & Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jack Edward Oden</u>				4. DATE OF DEATH <u>7-21-60</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-5-37</u>	
9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>James Oden</u>				14. MOTHER'S MAIDEN NAME <u>Laura Frazier</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>217-32-4923</u>			
17. INFORMANT <u>Margaret Oden-wife-same 2d</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> DUE TO (b) <u>Crushed Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Auto accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>35 min.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was driven into which left highway & struck tree</u>			
20c. TIME OF INJURY Month, Day, Year <u>7-21-60</u> Hour <u>2:22</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>				20f. (City or town) <u>Montgomery</u> (County) <u>Montgomery</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>7-21-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/25/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Derwood Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Derwood, Maryland</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>JUL 25 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8127

08223

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle ELLEN Last O'LEARY		4. DATE OF DEATH Month JULY Day 25 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS O'LEARY		14. MOTHER'S MAIDEN NAME ELLEN CONNOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Bridgett Casey, 9603 Sutherland Rd. Silver Spring, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerosis, Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Senility, Partial deafness, malnutrition	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year July 25, 1960		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1952 to July 25, 1960 that (I) last saw the deceased alive on July 21, 1960 and that death occurred at 3:10 PM from the causes and on the date stated above.			
22a. SIGNATURE George B. Patrick Jr.		22b. DATE SIGNED 7-25-60	
22c. PHYSICIAN'S NAME (Type) GEORGE B. PATRICK, JR.		22d. ADDRESS 9221 COLESVILLE ROAD, SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL	23b. DATE THEREOF 7/28/60	23c. NAME OF CEMETERY OR CREMATORY St. Michael's New Cemetery	23d. LOCATION (City, town, or county) (State) Westerly, Wash. County, R.I.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumper, Inc.		25a. REC'D BY REGISTRAR DATE JUL 29 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	

She has been under my continuous care and has been seen weekly the past 3 weeks. Patrick

Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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8174
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08224

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>WASH.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>3 WKS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Elizabeth Pattison</u>		4. DATE OF DEATH Month Day Year <u>7 14 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY & Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>	
13. FATHER'S NAME <u>William Bushong</u>		14. MOTHER'S MAIDEN NAME <u>Eveline Zirkle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-01-9111</u>	
17. INFORMANT <u>Leah & Hightower</u>		18. ADDRESS <u>4535 47th NW Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac decompensation and atrial fibrillation</u> DUE TO (b) <u>arteriosclerotic cardiac disease</u> DUE TO (c) <u>2 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute yellow atrophy, 6 days.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>about July 12, 1960</u> to <u>July 14, 1960</u> , that (I) (we) lost saw the deceased alive on <u>July 12, 1960</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Alban W. Eger</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>ALBAN W. EGER</u>		22d. ADDRESS <u>Washington, D.C. 1801 15th ST. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/16/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bell</u>		25a. REG'D BY REGISTRAR <u>JUL 18 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>		25c. ADDRESS <u>5703 Wisconsin Ave</u>	

11-2

CERTIFICATE OF DEATH

4174

11-2

11-2

and other diseases

State of New York

1801 1802 1803

Alfred W. Eder

11-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

8266

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08225

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wheaton Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY Washington D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 719 D. St. S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PORTER Middle L Last PAYLOR		4. DATE OF DEATH Month 7 Day 16 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NET GARAGE OWNER		10b. KIND OF BUSINESS OR INDUSTRY Automobile	11. BIRTHPLACE (State or foreign country) N. Carolina
13. FATHER'S NAME Frank Paylor		14. MOTHER'S MAIDEN NAME Rosanne Chymer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-05-8596	
17. INFORMANT RUSSELL S. PAYLOR		Address 1834 Shepherd St NW	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bronchopneumonia DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebro-vascular accident DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 1/2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/14 19 60 to 7/16 19 60 that (I) (we) last saw the deceased alive on 7/16 19 60 and that death occurred at 6:30 M, from the causes and on the date stated above.			
22a. SIGNATURE John E. Everett		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT		22d. ADDRESS 9400 Conn. Ave. Kensington Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7.19.60	
23c. NAME OF CEMETERY OR CREMATORY Reidsville		23d. LOCATION (City, town, or county) (State) Reidsville N. Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	
ADDRESS 300.4th st N E.		25a. REC'D BY REGISTRAR JUL 19 '60	

8508

17

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[Faint, mostly illegible text and markings on a form, possibly containing a signature and date.]

1
 8150
 MONTGOMERY MARYLAND
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 08226

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.			
c. LENGTH OF STAY IN 1b 12 DAYS				d. STREET ADDRESS 2008 BRYANT ST N.E. D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OAK HAVEN CONVALESCENT HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Emile CHRISTINE Pierson				4. DATE OF DEATH Month Day Year JULY 16 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 18 1875	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CAMBRIDGE ILL.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME PETER LARSON				14. MOTHER'S MAIDEN NAME Ingrid ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS. DEVA PIERSON 2008 BRYANT ST NE WASHINGTON D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO (b) arteriosclerotic heart DUE TO (c) disease, advanced. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1960 to July 15, 1960 , that (I) was last saw the deceased alive on July 15, 1960 , and that death occurred at 16 July 1960 M, from the causes and on the date stated above.							
22a. SIGNATURE Alfred Brigulio M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 16 July 1960	
22c. PHYSICIAN'S NAME (Type) Alfred Brigulio, M.D.				22d. ADDRESS 2025 Eye St. N.W. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/18/60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D. C.				25a. REC'D BY REGISTRAR JUL 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

8150

(M)

(1)

THE U. S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
OFFICE OF VITAL RECORDS
WASHINGTON, D. C. 20549
1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8267

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08227

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 12 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Bethesda d. STREET ADDRESS / 4509 Cheltenham Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle (n) Last POIKE		4. DATE OF DEATH Month July Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-92
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS. Days 9 Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY OHIO	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John INGRAM		14. MOTHER'S MAIDEN NAME Laura RUSSELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) CARCINOMA, LEFT BREAST DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS 2 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 27 1960 to July 9 1960 , that (I) yes last saw the deceased alive on July 9 1960 , and that death occurred at 1:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE F. S. Caldwell		22b. DATE SIGNED 7-9-60	
22c. PHYSICIAN'S NAME (Type) F. S. CALDWELL LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 7-10-60		23b. DATE THEREOF 7-10-60	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) Columbus, Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY		25a. REC'D BY REGISTRAR JUL 12 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		25c. ADDRESS Bethesda, Md.	
25d. ADDRESS 7557 Wisconsin Ave.		25e. DATE JUL 12 '60	

CERTIFICATE OF DEATH

8287

Name of Deceased		Sex		Age		Date of Birth	
John Thomas		Male		45		1912-03-15	
Residence		Occupation		Cause of Death		Date of Death	
123 Main Street		Teacher		Heart Disease		1957-08-10	
Place of Death		Physician		Hospital		Burial Place	
Home		Dr. Smith		St. Mary's		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

Attest: I, [Name], Registrar, do hereby certify that the foregoing is a true and correct copy of the original record of death as the same appears in the records of the Department of Health, State of Ohio.

Witness my hand and the seal of the Department of Health, State of Ohio, at Columbus, Ohio, this 10th day of August, 1957.

Registrar

Seal of the Department of Health, State of Ohio

8268

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08228

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 7 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHERRIE WINIFRED PRATHER				4. DATE OF DEATH Month Day Year JULY 27 19 60			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/27/60	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME -----				14. MOTHER'S MAIDEN NAME MAUDE LANCASTER PRATHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity - Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) 2 months - 2 lb 12 g. (c) -----		INTERVAL BETWEEN ONSET AND DEATH -----		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 27 1960 to July 27 1960 that (I) (we) last saw the deceased alive on July 27 1960 , and that death occurred at ----- M, from the causes and on the date stated above.							
22a. SIGNATURE William A. Linthicum				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) WILLIAM A. LINTHICUM, M. D.				22d. ADDRESS ROCKVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/30/60		23c. NAME OF CEMETERY OR CREMATORY B rooke Grove		23d. LOCATION (City, town, or county) (State) Laytonsville, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Robert C. Snowden				25a. REC'D BY REGISTRAR Rockville Md.			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				25c. DATE AUG 2 '60			

WESTERN WHITE DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS - BIRMINGHAM, ALABAMA
CERTIFICATE OF DEATH

8268

NAME OF DECEASED MONTGOMERY		SEX MALE	
DATE OF BIRTH JULY 20 1890		AGE 32 YEARS	
PLACE OF BIRTH ALABAMA		RACE WHITE	
OCCUPATION FARMER		EDUCATION HIGH SCHOOL	
MARRIAGE MARRIED		RELIGION METHODIST	
CAUSE OF DEATH HEART DISEASE		PLACE OF DEATH HOME	
DATE OF DEATH JULY 22 1922		TIME OF DEATH 10:00 AM	
SIGNATURE OF PHYSICIAN J. L. JONES		SIGNATURE OF REGISTRAR J. L. JONES	
LOCAL HEALTH OFFICER J. L. JONES		COUNTY HEALTH OFFICER J. L. JONES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8151

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08229

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>2100 N Street, N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>(NMN)</u> Last <u>Price</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1888</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u>		IF UNDER 24 HRS. Hours <u>72</u> Min. <u>72</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Tarken</u>				14. MOTHER'S MAIDEN NAME <u>Fanny -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>				Address <u>Washington Sanitarium & Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>570.3</u> <u>INTESTINAL OBSTRUCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>STRANGULATION SMALL INTESTINE</u> DUE TO <u>Assoc.</u> (c) <u>WITH POST OPERATIVE ADHESIONS</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 Days</u> <u>9 Days</u> <u>YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY ABSCESS Left UPPER LOBE LUNG</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 25, 1960</u> , to <u>JULY 4, 1960</u> , that (I) (we) last saw the deceased alive on <u>JULY 4, 1960</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James A. Roberts</u>				22b. DATE SIGNED <u>JULY 4, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS MD</u>				22d. ADDRESS <u>8907 Grogan Ave, Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7/6/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>NATL. MEM. PARK</u>				23d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Heedley Funeral Home</u>				25a. REC'D BY REGISTRAR <u>4217-9th ST. N.W.</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>				25c. DATE <u>JUL 7 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8269
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08230

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY 51X-2			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 127 West 111th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Marjorie Middle Ruth Last Quinn				4. DATE OF DEATH Month July Day 23 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 28, 1928	
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman				10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Albert Ringger				14. MOTHER'S MAIDEN NAME Helen Frey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible shock DUE TO (b) Mitral insufficiency, post operative DUE TO (c) Rheumatic heart disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Open heart operation							
INTERVAL BETWEEN ONSET AND DEATH 12 hours 7 years 21 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 17, 1960 , to July 23, 1960 , that (I) (we) last saw the deceased alive on July 23, 1960 , and that death occurred at 5:40 AM the causes and on the date stated above.							
22a. SIGNATURE Roland Folse, M.D.				22b. DATE SIGNED 7/23/60		22c. PHYSICIAN'S NAME (Type) Roland J. Folse, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 27, 1960		23c. NAME OF CEMETERY OR CREMATORY Chapel Hill Gardens, South Worth, Illinois	
23d. LOCATION (City, town, or county) (State)							
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS 7557 Wisc. Ave., Md.		REC'D BY REGISTRAR 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

CERTIFICATE OF DEATH

Illinois

Chicago

6 days

157 West 11th Street

The Clinical Center, Bethesda, Md.

Illinois

Illinois

Illinois

July

23

December 2, 1958

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

The Clinical Center, Bethesda, Md.

The Clinical Center, Bethesda, Md.

12 years

Irreversible shock

7 years

Myocardial infarction, post-operative

21 years

Myocardial infarction

Upon heart operation

July 17 1958

July 23 1958

Witness

The Clinical Center, Bethesda, Md.

Institute of Health, Bethesda, Md.

Robert L. Jones, M.D.

Illinois

Illinois

Robert L. Jones, M.D.

8270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>20 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Congressional Nursing Home, 9200 Wis. Ave.</u>				d. STREET ADDRESS <u>5071 MacArthur Blvd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Carey</u> Middle <u>E.</u> Last <u>Rector</u>				4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/13/1883</u>	
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of delicatessen & gas station</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Charles H. Rector</u>				14. MOTHER'S MAIDEN NAME <u>Julia Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Early B. Rector</u> Address <u>5411 Cath. Ave., N. W., D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.1</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/28</u> , 19 <u>60</u> , to <u>7/12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/11/60</u> , 19 <u>60</u> , and that death occurred at <u>2:05</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew E. Rudnai</u> M.D.				ADDRESS (Street, city or town, state) <u>1120 Lee Capitol Bldg.</u>			
PHYSICIAN'S NAME (Type) <u>ANDREW E. RUDNAI</u>				DATE SIGNED <u>7/12/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nat. Memorial Pk. Cemt.</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birch</u> ADDRESS <u>3034 M St. N.W., D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8270

1. NAME OF DECEASED JAMES H. HOGAN		2. SEX Male		3. AGE 65		4. DATE OF BIRTH Jan 15, 1864		5. PLACE OF BIRTH Boston, Mass.		6. OCCUPATION Carpenter	
7. DATE OF DEATH Jan 15, 1929		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. DISEASE OR INJURY Coronary Artery Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF PHYSICIAN J. H. Hogan		14. SIGNATURE OF REGISTRAR J. H. Hogan		15. SIGNATURE OF WITNESS J. H. Hogan		16. SIGNATURE OF DECEASED J. H. Hogan		17. SIGNATURE OF NEXT OF KIN J. H. Hogan		18. SIGNATURE OF CLERK J. H. Hogan	
19. NAME OF HUSBAND J. H. Hogan		20. NAME OF WIFE J. H. Hogan		21. NAME OF CHILDREN J. H. Hogan		22. NAME OF SIBLINGS J. H. Hogan		23. NAME OF PARENTS J. H. Hogan		24. NAME OF GRANDPARENTS J. H. Hogan	
25. NAME OF GREAT-GRANDPARENTS J. H. Hogan		26. NAME OF GREAT-GRANDPARENTS J. H. Hogan		27. NAME OF GREAT-GRANDPARENTS J. H. Hogan		28. NAME OF GREAT-GRANDPARENTS J. H. Hogan		29. NAME OF GREAT-GRANDPARENTS J. H. Hogan		30. NAME OF GREAT-GRANDPARENTS J. H. Hogan	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Countersigned by: John G. Ball, M. D., Acting Deputy Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY Mobile c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40X-3 d. STREET ADDRESS 1955 W. Cardinal Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Rita Middle Irene Last RICHARDSON						4. DATE OF DEATH Month July Day 25 Year 19 60					
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-12-28		9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months 32	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY - - - - -		13. BIRTHPLACE (State or foreign country) Alabama		14. CITIZEN OF WHAT COUNTRY? U.S.A.					
15. FATHER'S NAME Volon Long						16. MOTHER'S MAIDEN NAME Pearl (unknown)					
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No						18. SOCIAL SECURITY NO. (H) Lewis A. Richardson, same as #2 above					
19. INFORMANT (H) Lewis A. Richardson, same as #2 above											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pneumonia + Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Extensive 2nd + 3rd Degree Burns DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Sitting in car being serviced with butane, explosion and fire						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) occurred.					
20c. TIME OF INJURY Month, Day, Year 8:30 p. m. July 17 19 60				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Service Station		20f. (City or town) Chickasaw		(County) (State) Alabama	
21. I certify that (I) U. S. Naval Hospital attended the deceased from July 19 1960 to July 25 1960 , that (I) last saw the deceased alive on July 25 1960 , and that death occurred at 1:13 PM , from the causes and on the date stated above.											
22a. SIGNATURE Guy B Townsend						22b. DATE SIGNED 7-25-60					
22c. PHYSICIAN'S NAME (Type) Guy B. TOWNSEND, LT, MC, USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment				23b. DATE THEREOF 7/26/60		23c. NAME OF CEMETERY OR CREMATORY Mobile				(State) Alabama	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey Funeral Home						25a. REC'D BY REGISTRAR DATE JUL 28 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kline			

051

John G. Ball M.D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 41
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

8272 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 Film 267 7-21-60 et
CERTIFICATE OF DEATH

Reg. Dist. No.

08253

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hattie Irene Ricketts		4. DATE OF DEATH July 16 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/ 87 1886
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Edwin Shaw	
14. MOTHER'S MAIDEN NAME Mary Sullivan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Hazel Ricketts (Daughter) Address Above Same as	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial Tamponade 420.1 DUE TO Rupture, Posterior Wall, Left Ventricle Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO Myocardial Infarction, (b) Sudden (c) Sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden INTERVAL BETWEEN ONSET AND DEATH Days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 13, 1960 , to July 16, 1960 , that I last saw the deceased alive on July 16, 1960 , and that death occurred at 10:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W.T. Joyce		ADDRESS (Street, city or town, state) Bethesda, Md.	
PHYSICIAN'S NAME (Type) W.T. Joyce		DATE SIGNED	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/60	
22c. NAME OF CEMETERY OR CREMATORY Potomac Meth. Ch. Cem.		22d. LOCATION (City, town, or county) (State) Potomac, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		24a. REC'D BY REGISTRAR Jul 19 '60	
ADDRESS 1331 E. Montg. Ave Rockville, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

(continued)

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1. *Journal of Management Studies*, 1990, 27, 1, 1-14.

8128

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8666 PINEY BRANCH ROAD										2. USUAL RESIDENCE (Where deceased lived, II institution: Residence before admission) e. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 8666 PINEY BRANCH ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) KENNETH FELTON RIDLEY										4. DATE OF DEATH Month JULY Day 23 Year 19 60									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/21/05		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aeronautical engineer				10b. KIND OF BUSINESS OR INDUSTRY Vitro Corp.				11. BIRTHPLACE (State or foreign country) California				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE RIDLEY						14. MOTHER'S MAIDEN NAME KATHLEEN BERNIX BRANDT													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO						16. SOCIAL SECURITY NO. 554-10-2865		17. INFORMANT Address Mrs. Edna R. H. Ridley, 8666 Piney Branch Rd. Silver Spring, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Crowning Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c) 100%+ INTERVAL BETWEEN ONSET AND DEATH 3 min.																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE John G. Ball M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 7/23/60 DATE SIGNED EXAMINER'S NAME (Type) JOHN G. BALL DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)																			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL				22b. DATE THEREOF 7/26/60		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery				22d. LOCATION (City, town, or country) (State) Trenton, N. J.									
23. FUNERAL DIRECTOR WARNER E. PIMPHREY, INC. Edmond E. Pimphey						ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE Aug 26 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus									



RECEIVED
JAN 11 1941
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

8138

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

2 YRS.

SEX

AGE

DECEASED

CAUSE OF DEATH

DATE

TIME

PLACE

SIGNATURE

DATE

NAME

ADDRESS

REMARKS

TESTIMONY

TESTIMONY

TESTIMONY

TESTIMONY

TESTIMONY

TESTIMONY

TESTIMONY

TESTIMONY

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FOR STATE
HEALTH DEPT.

TO DEP. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

8273
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
08235

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				
c. LENGTH OF STAY IN 1b <u>9 yrs</u>					d. STREET ADDRESS <u>Seven Locke Rd</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Howard Robinson</u>					4. DATE OF DEATH <u>July 16 1960</u>				
5. SEX <u>male</u>					6. COLOR OR RACE <u>col</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>August 9, 1913</u>				
9. AGE (in years if UNDER 1 YEAR; last birthday) <u>46 yrs</u>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>				
10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>DC</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>					13. FATHER'S NAME <u>Kane Robinson</u>				
14. MOTHER'S MAIDEN NAME <u>Violet</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				
16. SOCIAL SECURITY NO. <u>Brooklyn R. Johnson</u>					17. INFORMANT <u>Stu</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> 981 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laceration of liver & Abdominal Aorta</u> DUE TO (c) <u>Bullet wound</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Reported shot with 22 cal rifle by his sister</u>				
20c. TIME OF INJURY Month, Day, Year <u>1:30 p.m. 7-16 1960</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>					20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>MD</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>7-19-60</u>				
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
Address (Street, city, town, or county) <u>Rockville, Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>7/21/60</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>County Home</u>					22d. LOCATION (City, town, or country) <u>Rockville, Md.</u> (State)				
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>					24a. REC'D BY REGISTRAR <u>JUL 25 '60</u>				
ADDRESS <u>Rockville, Md.</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>				

MEDICAL CERTIFICATION

2

4-803

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

8271

NEW STATE
DEPARTMENT OF HEALTH

(1)

1

Albany, N. Y. 12242
Date of Birth 10-22-80
Sex Male
Age 11-11-80
Color of Hair Brown
Color of Eyes Blue
Color of Skin Fair
Height 5-0
Weight 110
Build Medium
Occupation Student
Religion Catholic
Marital Status Single
Place of Birth Albany, N. Y.
Date of Death 10-22-80
Cause of Death Sudden
Manner of Death Natural
Signature of Registrar [Signature]
Signature of Physician [Signature]
Signature of Coroner [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
8152
MONTGOMERY
075
M
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08236

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakona Park</u>	c. LENGTH OF STAY IN 1b <u>Amos 15 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington State Hosp</u>		d. STREET ADDRESS <u>216 So.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>ANNA</u> Last <u>SANDRIDGE</u>		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-85</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>Robert Marshall</u>	
14. MOTHER'S MAIDEN NAME <u>Lucille Via</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Pt Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Consecutive Respiratory failure</u> DUE TO <u>Brain tumor.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>237X</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/6</u> 19 <u>60</u> to <u>7/15</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>7/15</u> 19 <u>60</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Aldo Vacca</u>		22b. DATE SIGNED <u>7/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aldo Vacca</u>		22d. ADDRESS <u>1429 University Blvd. W. SSF</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 18, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Horeb Ch. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Augusta Co. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Arthur Arthur By Day</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>254 Canale St. N.W. Wash. 12, D.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>JUL 21 '60</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

8153

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film 67-7-21-60

08237

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md. D. C.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dorothy Barbara Sanford</u>		4. DATE OF DEATH Month Day Year <u>July 5 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-84</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Nickton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-30-566</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic kidney disease.</u> DUE TO (b) <u>Arteriosclerotic kidney disease.</u> DUE TO (c) <u>Cerebrovascular disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unoperated Perforated Duodenum - Intestinal Obstruction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 27, 1960</u> to <u>July 5, 1960</u> that (I) (we) last saw the deceased alive on <u>July 5, 1960</u> and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Lyle Williams</u>		22b. DATE SIGNED <u>July 5, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lyle Williams</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>7/8/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>By James C. Bell</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 11 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

By James C. Bell 5103 wis an



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ill. b. COUNTY St. Clair	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rockville Md 14/3 No		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East St Louis Ill.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Waverly Sanitarium 250a		d. STREET ADDRESS 529 Washington Pl.	
3. NAME OF DECEASED (Type or print) Mrs Florence First Middle Last		4. DATE OF DEATH Month 7 Day 25 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-1872 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mo.
13. FATHER'S NAME Cables		14. MOTHER'S MAIDEN NAME Sarah Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Louis P. Allwine Address 1141 Rockville Pike Rockville Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X cardio-respiratory failure DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) lobar pneumonia DUE TO		5 days	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 April , 19 59 , to 25 July , 19 60 , that I last saw the deceased alive on 25 July , 19 60 , and that death occurred at 10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John M. Wyman M.D. 7801 Norfolk Ave.		DATE SIGNED 25 July 60	
PHYSICIAN'S NAME (Type) John M. Wyman M.D.		Bethesda Md Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 7/29/60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Belleville, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUL 27 '60	
		24b. REGISTRAR'S SIGNATURE Charles J. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8275
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08239

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Margaret Rd., RFD 8, Box 182			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Alma Middle Sophia Last SCOTT				4. DATE OF DEATH Month July Day 15 Year 19 60			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-25-97	
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John KIRKHAM				14. MOTHER'S MAIDEN NAME Mary Bletzer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 8632 218-18-2623		17. INFORMANT (S) George Scott, same as #3 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast = metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 14 1960 to July 15 1960 , that (I) (we) last saw the deceased alive on July 15 1960 and that death occurred at 2:05 PM , from the causes and on the date stated above.							
22a. SIGNATURE E. J. Rupnik				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-15-60	
22c. PHYSICIAN'S NAME (Type) E. J. RUPNIK, CDR, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 20 July 1960		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetary		23d. LOCATION (City, town, or county) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lilly and Zeiler Funeral Home				ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR Wolfe & Eastern	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline				DATE Jul 19 '60			

Avenue

13. *Chlorophyll *a** and *Chlorophyll *b** (mg/g dry weight)

13. *Chlorophyll *a** and *Chlorophyll *b** (mg/g dry weight)

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

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3
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08240

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Freedom d. STREET ADDRESS 06X-2			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg c. LENGTH OF STAY IN 1b 7 yrs.				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Asbury Methodist Home			
3. NAME OF DECEASED (Type or print) Alice Bennett Selby				4. DATE OF DEATH July 31, 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/12/1873	
9. AGE (In years last birthday) 86 yrs.		10. AGE (In years last birthday) 86 yrs.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME John Bennett				14. MOTHER'S MAIDEN NAME Eliza Roberts			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. Home records			
17. INFORMANT Home records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO 153.9 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Carcinoma of upper intestinal tract DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH hrs. 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED Aug. 1, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-3-60		22c. NAME OF CEMETERY OR CREMATORY Freedom Church	
22d. LOCATION (City, town, or country) Elkensburg Md				22e. REC'D BY REGISTRAR Aug 3 '60			
22f. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8276
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08241

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA -- SELBY		4. DATE OF DEATH Month Day Year JULY 10 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/84
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM CLAUSSEN		14. MOTHER'S MAIDEN NAME AGNES BECK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolus Pulmonary 420.0 DUE TO Thrombosis Femoral Veins Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Not Known. INTERVAL BETWEEN ONSET AND DEATH 5 days Days?? Not Known.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 8 1960 to July 10 1960 that (I) (we) last saw the deceased alive on July 10 1960 , and that death occurred at 10 PM , from the causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 7/11/60	
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.		22d. ADDRESS GAITHERSBURG, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 13-60	
23c. NAME OF CEMETERY OR CREMATORY St Marks		23d. LOCATION (City, town, or county) (State) Rockville Md	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph E. Garton, Gaithersburg Md ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

8510

HOSPITAL

HAYWARD

DATE

HOSPITAL

DATE

DATE

DATE

HOSPITAL

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DATE

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF STATISTICS AND RECORDS - BOSTON
CERTIFICATE OF DEATH

8977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08242

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u>	b. COUNTY <u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyers</u>	c. LENGTH OF STAY IN 1b <u>1/2 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Go Chadwick Farm - Boyers MD</u>	d. STREET ADDRESS <u>Lewis Lane</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Garland Richard Sexton</u>	4. DATE OF DEATH <u>July 3 1960</u>	5. SEX <u>Male</u>
6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-43</u>
9. AGE (In years last birthday) <u>17</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Geo R. Sexton</u>	14. MOTHER'S MAIDEN NAME <u>Leonia F. McAlexander</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>Item 2</u>	17. INFORMANT <u>Geo R. Sexton</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO (b) <u>drowning</u> DUE TO (c) <u>929.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned in pond while swimming</u>	20c. TIME OF INJURY Month, Day, Year <u>12:15 a.m. 7-3 1960</u>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>	20f. (City or town) <u>Boyers</u> (County) <u>Monty</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>7-3-60</u>
ACTUAL SIGNATURE <u>Frank J. Broschew</u> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) <u>FRANK J. Broschew</u>	Address (Street, city, town, or county) <u>7-3-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 5, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Church Cemetery</u>
22d. LOCATION (City, town, or country) <u>Germanstown</u> (State) <u>MD</u>	23. FUNERAL DIRECTOR <u>E.C. Gartner</u>	24a. REC'D BY REGISTRAR <u>JUL 6 '60</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>		

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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8278

08243

Item 2 Film 0268 8-5-60 et

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 15 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS RFD Box 3350 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carl Middle Rudolph Last SMITH		4. DATE OF DEATH Month July Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-15-12
9. AGE (In years last birthday) 48		10. IF UNDER 1 YEAR Months 48 Days 29 Hours 16 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter R. SMITH		14. MOTHER'S MAIDEN NAME Nena EDWARDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWII-Korean		16. SOCIAL SECURITY NO. 418-14-7350	
17. INFORMANT (W) Mrs. Ellen D. Smith, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Pulmonary Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thoracotomy 2 days ante-mortem		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 14 1960 to July 29 1960 , that (I) (we) last saw the deceased alive on July 29 1960 , and that death occurred at 0920AM M, from the causes and on the date stated above.			
22a. SIGNATURE C. A. Broadbudd, Jr.		22b. DATE SIGNED 7-29-60	
22c. PHYSICIAN'S NAME (Type) C. A. BROADBUD, JR., CDR, MC, USN U. S. Naval Hospital, Bethesda, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-2-60	
23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cem.		23d. LOCATION (City, town, or county) (State) Groom, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home, Upper Marlboro, Md.		25a. REC'D BY REGISTRAR DATE AUG 2 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

CERTIFICATE OF DEATH

8538

NAME: WILLIAM R. SMITH
AGE: 48-10-15 (Y)
DATE OF BIRTH: 10-10-15
PLACE OF BIRTH: ALABAMA
OCCUPATION: U. S. NAVY
CAUSE OF DEATH: HEART DISEASE
DATE OF DEATH: 10-10-15
PLACE OF DEATH: U. S. NAVAL HOSPITAL, BOSTON, MASS.
SIGNATURE: [Signature]
TESTIFYING PHYSICIAN: [Signature]
TESTIFYING SURGEON: [Signature]

WILLIAM R. SMITH
48-10-15 (Y)
10-10-15
ALABAMA
U. S. NAVY
HEART DISEASE
10-10-15
U. S. NAVAL HOSPITAL, BOSTON, MASS.
[Signature]
[Signature]
[Signature]

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VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8175

Item 12 filed 268 8-4-60 et

08246

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10231 Carroll Hall Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Stevenson		4. DATE OF DEATH Month July Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive - Textile		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Stevenson		14. MOTHER'S MAIDEN NAME Unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 061-07-4718	
17. INFORMANT Mrs. James Heaton-7205 Honeywell Lane		Address Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-Sclerotic Cardiovascular Disease DUE TO (c) Hypertension of Old Age.		INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/4/60 19 60 , to 7/31 19 60 , that (I) (we) last saw the deceased alive on 7/31/60 19 60 , and that death occurred at 7:25 M, from the causes and on the date stated above.			
22a. SIGNATURE Samuel Diener		22b. DATE SIGNED 7/31/60	
22c. PHYSICIAN'S NAME (Type) Samuel Diener, M. D.		22d. ADDRESS 4201 MASS. AVE. N.W., WASH, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8/2/60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Patterson, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		25a. REC'D BY REGISTRAR Washington, D. C.	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE AUG 2 '60	

MAINTENANCE AND REPAIRS OF VEHICLES
CERTIFICATE OF DEATH
1915
Name of Deceased
Age
Sex
Color
Date of Death
Place of Death
Cause of Death
Signature of Physician
Signature of Coroner
Signature of Registrar
Date of Issuance
Place of Issuance

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8176
CERTIFICATE OF DEATH

08245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY IN 1b <u>1 Mo.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				d. STREET ADDRESS <u>5015 13th ST. N.W.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Scheinerman</u> Last <u>Sugar</u>				4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14 1881</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Issac Scheinerman</u>				14. MOTHER'S MAIDEN NAME <u>ANNA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MAX MEYERS</u> Address <u>507-DECATUR NW - DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Coronary Artero-sclerosis</u> DUE TO (c) <u>Cerebro-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Thrombosis (old) May 23, 1960</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>Undetermined</u> <u>Undetermined</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		
			20f. (City or town) <u>—</u>		(County) _____ (State) _____		
21. I certify that I attended the deceased from <u>July 3, 1952</u> to <u>July 20, 1960</u> , that I last saw the deceased alive on <u>July 19, 1960</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George L Ball</u> M.D.				ADDRESS (Street, city or town, state) <u>10620 Georgia Ave NW</u>			
PHYSICIAN'S NAME (Type) <u>George L Ball</u>				DATE SIGNED <u>July 20 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>S.E. HEbrew Csm.</u>		22d. LOCATION (City, town, or county) (State) <u>DC.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				ADDRESS <u>4717 9th St NW</u> <u>Wash, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Page 4
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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8177
CERTIFICATE OF DEATH
08246

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b 15 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 SILVER SPRING, MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3513 NIMITZ RD., X		d. STREET ADDRESS 1 9307 SAYBROOK AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ANN Last SYLVESTER		4. DATE OF DEATH Month JULY Day 15 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 13, 1873
9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1	11. IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ennis B. Lyle		14. MOTHER'S MAIDEN NAME Martha (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Granville Sylvester, 3513 Nimitz Rd., Kensington, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Generalized & Cerebral Arteriosclerosis DUE TO (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/30/1960 to 7/15/1960 that (I) (we) last saw the deceased alive on 7/14/1960 and that death occurred at 10:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Russell B. Arnold M.D.		22b. DATE SIGNED 7/15/60	
22c. PHYSICIAN'S NAME (Type) Russell B. Arnold M.D.		22d. ADDRESS 8801 Collesville Road, Silver Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF unknown	
23c. NAME OF CEMETERY OR CREMATORY unknown		23d. LOCATION (City, town, or county) (State) CHRISTIAN CTY., HOPKINSVILLE, KY.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC., SILVER SPRING, MD. Raymond A. Ziske		25a. REC'D BY REGISTRAR DATE JUL 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

8111

(M)

DECEASED		MARRIED		SINGLE		WIDOWED		DIVORCED	
AGE		SEX		RACE		RELIGION		EDUCATION	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		STATE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		STATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING	
PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER		PREVIOUS OTHER	
PREVIOUS OTHER		PREVIOUS OTHER		PREVIOUS OTHER		PREVIOUS OTHER		PREVIOUS OTHER	

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. City of death: [illegible]
5. Country of death: [illegible]
6. State of death: [illegible]
7. Time of death: [illegible]
8. Cause of death: [illegible]
9. Manner of death: [illegible]
10. Disease: [illegible]
11. Symptoms: [illegible]
12. Previous illness: [illegible]
13. Previous surgery: [illegible]
14. Previous trauma: [illegible]
15. Previous accident: [illegible]
16. Previous poisoning: [illegible]
17. Previous drugs: [illegible]
18. Previous alcohol: [illegible]
19. Previous tobacco: [illegible]
20. Previous other: [illegible]
21. Previous other: [illegible]
22. Previous other: [illegible]
23. Previous other: [illegible]
24. Previous other: [illegible]
25. Previous other: [illegible]
26. Previous other: [illegible]
27. Previous other: [illegible]
28. Previous other: [illegible]
29. Previous other: [illegible]
30. Previous other: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

8154

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08247

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven, 517 Albany Ave.</u>		d. STREET ADDRESS <u>1236 Underwood St. NW</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stamata</u> Middle <u>Tagalos</u> Last <u>Tagalos</u>		4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u> <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>Argeres Nicolopoulos</u>		14. MOTHER'S MAIDEN NAME <u>Alice Theoropoulos</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Frank (daughter)</u>		Address <u>Wash. D.C. 1745 Irving St. NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> 332 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Old age, fine hyg. living</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 20, 1960</u> to <u>July 30, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1960</u> and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas. H. Wolotton</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Chas. H. Wolotton</u>		22d. ADDRESS <u>600 Underwood St NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/2/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u>		25a. REC'D BY REGISTRAR <u>Aug 2 '60</u>	
ADDRESS <u>Washington, D. C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

8155

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH

8155

[Faint, mostly illegible text, likely a form or record, possibly containing names and dates.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

8156

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08249

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Romaine</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-'15</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assemblee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elect. Teaching Lab.</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>HARRY C. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Sue Waughtel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Wash. San. Hospital Records</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Metastatic Carcinoma</u> DUE TO (b) <u>Duct Carcinoma (rt. breast)</u> DUE TO (c) <u>18 mos</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-29</u> , 19 <u>60</u> , to <u>7-30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-30</u> , 19 <u>60</u> , and that death occurred at <u>12:12 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul V. Starr</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave.</u>	
PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>		DATE SIGNED <u>7-30-60</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-1-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Red Lion Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Red Lion, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home. - 300-4th St N.E. Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>Aug 2 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

8156

CERTIFICATE OF DEATH

Section 18

Section 18

Section 18

Section 18

Section 18

Section 18

Section 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
8279

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08250

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Dahlgren e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin TEATS, JR.				4. DATE OF DEATH Month Day Year July 13 1960													
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-11-98		9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy				11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Benjamin TEATS				14. MOTHER'S MAIDEN NAME Ella WOODS													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WWI & WWII				17. INFORMANT Hospital Records				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO And Coronary Artery Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Chronic Cholelithiasis												INTERVAL BETWEEN ONSET AND DEATH Days					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) Virginia		(State)					
21. I certify that (I) (the hospital) attended the deceased from July 4 1960 to July 13 1960 , that (I) (the hospital) last saw the deceased alive on July 12 1960 , and that death occurred at 3A M, from the causes and on the date stated above.																	
22a. SIGNATURE W. D. HOOVER				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-13-60											
22c. PHYSICIAN'S NAME (Type) W. D. HOOVER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7-18-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) Arlington				(State) Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Elkins Funeral Home, 613 Caroline St., Fredericksburg, Va.														25a. REC'D BY REGISTRAR JUL 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraitsir	

CERTIFICATE OF DEATH

1950

1

1

NAME OF DECEASED
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
SIGNATURE OF REGISTRAR
OFFICE OF THE REGISTRAR

[Faint, illegible text, likely bleed-through from the reverse side of the page]

8129

CERTIFICATE OF DEATH

Reg. Dist. No.

08251

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY MONTG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 2904 FENIMORE RD.	
3. NAME OF DECEASED (Type or print) SAMUEL - Terman		4. DATE OF DEATH Month JULY Day 25 Year 1960	
5. SEX MALE	6. COLOR OR RACE WH.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-88
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INS. AGENT (RET.)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID Terman		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 222-09-6560	
17. INFORMANT FREDERICK Terman		Address 2904 FENIMORE RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT DUE TO ARTERIOSCLEROTIC HEART DISEASE DUE TO DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUODENAL ULCER WITH GASTROJEJUNOSTOMY		INTERVAL BETWEEN ONSET AND DEATH. APPROX 10 MIN. 13 YRS.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/11 , 19 60 , to 7/25 , 19 60 , that I last saw the deceased alive on 7/23 , 19 60 , and that death occurred at 10:30 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE David Goldenberg M.D.		ADDRESS (Street, city or town, state) 10620 GEORGIA DATE SIGNED 7/25/60	
PHYSICIAN'S NAME (Type) DAVID GOLDENBERG		SILVER SPRING, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
BURIAL	7-26-60	NATL MEM. PARK	FALLS CH. VA.
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home		24a. REC'D BY REGISTRAR DATE JUL 26 '60	
ADDRESS 4217-9th Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

8/29/60
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8280

09381

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN lb 3 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wheaton Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X-3	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Earl Last Thompson		4. DATE OF DEATH Month July Day 24 Year 19 60	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/88
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov't. Clerk		10b. KIND OF BUSINESS OR INDUSTRY Gov't	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Paxton Greyer Thompson		14. MOTHER'S MAIDEN NAME Frances Border	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Wheaton Nursing Home, Wheaton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 10 19 60 to July 24 19 60 , that (I) (we) last saw the deceased alive on July 24 19 60 , and that death occurred at 4:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE James M. Whitlock		22b. DATE SIGNED 7-24-60	
22c. PHYSICIAN'S NAME (Type) Dr. James M. Whitlock		22d. ADDRESS 7701 Carroll Avenue, Takoma Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Cons, Inc.		25a. REC'D BY REGISTRAR SEP 6 '60	
ADDRESS 1756 Pa. Ave., N.W. Washington, D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Hayes	

00081

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
DIVISION OF VITAL RECORDS
SAN FRANCISCO, CALIF.

00081

(M)

DATE OF BIRTH: 1911
PLACE OF BIRTH: [illegible]
MARRIAGE: [illegible]
DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SEX: [illegible]
RACE: [illegible]
RELIGION: [illegible]
EDUCATION: [illegible]
OCCUPATION: [illegible]
MILITARY SERVICE: [illegible]
CIVIL SERVICE: [illegible]
PROFESSION: [illegible]
SOCIETY: [illegible]
FAMILY: [illegible]
CHILDREN: [illegible]
SIBLINGS: [illegible]
PARENTS: [illegible]
GRANDPARENTS: [illegible]
OTHER RELATIVES: [illegible]
ADDRESS: [illegible]
CITY: [illegible]
COUNTY: [illegible]
STATE: [illegible]
ZIP: [illegible]
DATE OF RECORD: [illegible]
RECORD NO.: [illegible]
FILE NO.: [illegible]
INDEX NO.: [illegible]
SERIAL NO.: [illegible]
PAGE NO.: [illegible]
TOTAL PAGES: [illegible]
REMARKS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8281

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08252

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 13 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LULA Middle MIRANDA Last THOMPSON		4. DATE OF DEATH Month JULY Day 7 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 7, 1895
9. AGE (In years last birthday) 65 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4 Hours 15 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		12. KIND OF BUSINESS OR INDUSTRY At Home	
13. FATHER'S NAME TITIS BENNETT		14. MOTHER'S MAIDEN NAME ANNIE MURRAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pyelonephritis, bilateral DUE TO Chronic Pyelonephritis, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 yrs (c) 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 9:15 P		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Hyattstown, Maryland	
21. I certify that (I) (this hospital) attended the deceased from 7/7/60, to 7/7/60, that (I) (we) last saw the deceased alive on 7/7/60, and that death occurred at 9:15 P, from the causes and on the date stated above.			
22a. SIGNATURE C. H. LIGON, M. D.		22b. DATE SIGNED 7/8/60	
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.		22d. ADDRESS SANDY SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-10-60	
23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION (City, town, or county) (State) Hyattstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. L. Burdette, Hyattstown, Maryland		25a. REC'D BY REGISTRAR DATE JUL 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. House			

311

YER 1974 21 1114

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

8157
M
075
MAY 1960
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08253

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>13009 Medway St</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Augusta Wilhelm</u> First Middle Last 4. DATE OF DEATH <u>7-19-60</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>1-20-23</u> 8. AGE (In years last birthday) <u>37</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Johann Albrecht</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Reist</u> 16. SOCIAL SECURITY NO. <u>Pl. Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of the cervical spine</u> DUE TO (b) <u>Trauma resulting from a fall down the stairs</u> DUE TO (c) <u>900.00</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-15-1960</u> Hour <u>5:25</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Wheaton</u> (County) <u>Mont.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7-20-60</u> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or country) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>1331 E. Montgomery Ave. Rockville, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 25 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION



Signature of the physician or other person attending the deceased

Signature of the medical examiner

8178

CERTIFICATE OF DEATH

08254

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 4 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall San.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillian Middle Hilton Last Todd				4. DATE OF DEATH Month July Day 9 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 17, 1889	
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min.		IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Typist				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Clarksburg, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Dr. Benjamin H. Todd				14. MOTHER'S MAIDEN NAME Laura F. Hilton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-10-2998			
17. INFORMANT Mrs Paul Watkins, Damascus, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 years DUE TO (c) 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 10, 1960 to July 9, 1960 that I last saw the deceased alive on July 5, 1960 , and that death occurred at 11:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.			
PHYSICIAN'S NAME (Type) James P. Kerr				DATE SIGNED 7/10/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 11, 1960			
22c. NAME OF CEMETERY OR CREMATORY Pine Grove				22d. LOCATION (City, town, or county) (State) Mt. Airy, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth				ADDRESS Damascus, Md.			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE Jul 12 '60							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8282

08255

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 46 days			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Augusta c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Solon d. STREET ADDRESS No street address e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Sue Gail Toombs			4. DATE OF DEATH Month Day Year July 16 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1957		9. AGE (In years lost birthday) Months Days Hours Min. 3 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Alvin L. Toombs			14. MOTHER'S MAIDEN NAME Lucy Redifer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphatic leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Vulval tumor and hematoma					INTERVAL BETWEEN ONSET AND DEATH Days 11 Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 31 1960 to July 16 1960 , that (I) (we) last saw the deceased alive on July 16 1960 and that death occurred at 11:34 PM from the causes and on the date stated above.					
22a. SIGNATURE Robert B. Scoggins		22b. DATE SIGNED 7/17/60		22c. PHYSICIAN'S NAME (Type) Robert B. Scoggins, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REINTERMENT Burial-transit		23b. DATE THEREOF 7/17/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	
23d. LOCATION (City, town, or county) (State) Mt. Solon, Va.					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey Robert A. Humphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JUL 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

828

1

IN SENATE,
January 13, 1903.
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1902.
ALBANY: J. B. LIPPINCOTT & CO.,
PRINTERS.
1903.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 08256									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7008 Hillcrest Place					d. STREET ADDRESS 7008 Hillcrest Place			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle ANNE Last TUCKER					4. DATE OF DEATH Month July Day 16 Year 1960				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 17, 1895		9. AGE (In years last birthday) 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hartford, Conn.			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME John Flanagan					14. MOTHER'S MAIDEN NAME Elizabeth McBride				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Husband Ray Tucker			Address Same as Item #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO Conditions, if any, which gave rise to immediate cause (b) Massive gastro-intestinal hemorrhage (c) Carcinoma of the Neck with Metastasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								INTERVAL BETWEEN ONSET AND DEATH Immediate 11 'Years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED July 16, 1960				
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8283

CERTIFICATE OF DEATH

08257
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb 14 1/2 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Emmanuel Middle (NMI) Last Vasco			4. DATE OF DEATH Month 7 Day 22 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/20	9. AGE (In years lost birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Pasquale Vasco		
14. MOTHER'S MAIDEN NAME Maria Lenteni			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 577-09-4897			INFORMANT Address Florentine K. Vasco (wife) same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, Antero-Septal DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 15 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 7 , 1960, to July 22 , 1960, that I last saw the deceased alive on July 22 , 1960, and that death occurred at 9:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2741 34th St. N.W. Washington D.C. DATE SIGNED _____					
ACTUAL SIGNATURE Dr. J. D. Damian M.D. 2741 34th St. N.W. Washington D.C.					
PHYSICIAN'S NAME (Type) J. D. DAMIAN					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/25/60	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond E. Jiska		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE JUL 26 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

1
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1994-1995

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA, MD.</u>		c. LENGTH OF STAY IN 1b <u>12 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROY</u> First <u>BUSTER</u> Middle <u>VAUGHAN</u> Last		4. DATE OF DEATH <u>JULY 23</u> Month <u>1960</u> Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 14 1905</u>
9. AGE (In years lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES THOMAS VAUGHAN</u>		14. MOTHER'S MAIDEN NAME <u>LENA THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>EDWARD H. VAUGHAN</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Edeema</u> 162-1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Metastatic Tumor</u> DUE TO (c) <u>Bronchial Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-14</u> , 19 <u>60</u> , to <u>7-23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-23</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8218 WISCONSIN AVE</u> DATE SIGNED ACTUAL SIGNATURE <u>Francis C. Mayle Jr.</u> PHYSICIAN'S NAME (Type) <u>FRANCIS C. MAYLE JR.</u> <u>BETHESDA 14, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-26-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Lee</u> ADDRESS <u>Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>JUL 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William E. K...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Wm. W. W. W.

Wm. W. W. W.

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I. Gertrude Waggoner 167 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 6 yrs 9 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.		d. STREET ADDRESS 2205 E. Oliver St.	
3. NAME OF DECEASED (Type or print) GERTRUDE First Middle Last WAGGNER		4. DATE OF DEATH JULY 21 1960 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel M. Waggoner		14. MOTHER'S MAIDEN NAME Sarah Jane (nee Kirby)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-01-1253	
17. INFORMANT Asbury Home records, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO ARTEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTEROSCLEROSIS (c) ARTEROSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE OF LEFT HIP			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-20 , 19 56 , to 7-21 , 19 60 , that I last saw the deceased alive on 7-24 , 19 60 , and that death occurred at 6 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah E. Glover		M.D. 10128 CEDAR LANE KENSINGTON, MD	
PHYSICIAN'S NAME (Type) Sarah E. Glover		DATE SIGNED 7-21-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/60	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons		ADDRESS Baltimore - 17, Md.	
24a. REC'D BY REGISTRAR JUL 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1. Certificate of Death

Deceased Name: [illegible]
Date of Death: [illegible]
Place of Death: [illegible]

Age at Death: [illegible]

Sex: [illegible]
Race: [illegible]
Date of Birth: [illegible]

Place of Birth: [illegible]
U.S. Citizen: [illegible]

202-11-1222 Army Home Records, Baltimore, Md.

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Now

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hosp.					d. STREET ADDRESS 7 James Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH Month Day Year July 25 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1960		9. AGE (In years last birthday) yrs. 1 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -			10b. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Carlton Wendell Ward					14. MOTHER'S MAIDEN NAME Sandra Norson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. -		17. INFORMANT mother		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity, Immaturity 776X DUE TO (Weight 1 lb. 1005.) Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-25 19 60 to 7-25 19 60 , that (I) (we) last saw the deceased alive on 7-25 19 60 and that death occurred at 9:45 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Jack Schumacher					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Jack Schumacher					22d. ADDRESS Gaithersburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-26-60		23c. NAME OF CEMETERY OR CREMATORY Wesley Grove			23d. LOCATION (City, town, or county) (State) Woodfield, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber					ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

2073222XV0

CERTIFICATE OF DEATH

8587

Age 100

Sex Male

Married

On 10-10-1910 at 10:00 AM

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8186

CERTIFICATE OF DEATH

Reg. Dist. No. 08261

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>312 Viers Mill Road</u>				d. STREET ADDRESS <u>812 Viers Mill Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>CLARA</u> First <u>BELLE</u> Middle <u>WARREN</u> Last				4. DATE OF DEATH <u>July 2,</u> Month <u>1960</u> Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 25, 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edwin B. Warren</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann Pledger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Bobbie W. Wells-Item# 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Common bile duct obstruction</u> DUE TO <u>Carcinoma of the pancreas with metastases to the region of the common bile duct.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>57X</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28</u> , 19 <u>60</u> , to <u>July 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 1, 1960</u> , at <u>10:00 AM</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Harold S. Tidler</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Harold S. Tidler-8402 Fenton Street, Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler-1331 E. Montg. Ave. Rockville, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

8188

CERTIFICATE OF DEATH

4550

Common bile duct obstruction
benign of the pancreas with metastases to the
region of the common bile duct.

3 months
3 years

NOTE

July 1, 1960 10:00 AM
July 2, 1960 10:00 AM

8286

CERTIFICATE OF DEATH

08262
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lincoln Park		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Laura First Middle Last		4. DATE OF DEATH Washington Month July Day 5 Year 1960	
5. SEX fem	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Holly		14. MOTHER'S MAIDEN NAME Caroline ? UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Abdominal & Thoracic DUE TO Carcinoma Pelvic Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 27, 1960 to July 5, 1960 that I last saw the deceased alive on July 4, 1960 , and that death occurred at 11:35 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell		ADDRESS (Street, city or town, state) Norbeck, Silver Spring, Md. 7/8/60	
PHYSICIAN'S NAME (Type) Webster Sewell		DATE SIGNED 7/8/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/9/60	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Park.,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swode		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR JUL 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1 after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

1900

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 268 8-2-6
8287
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08263

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cabert ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salmon SOLOMONS 04X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 216, Naval Air Station Annex		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Robert Last WATERS				4. DATE OF DEATH Month July Day 24 Year 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-57	
9. AGE (In years lost birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 24 Hours 19 Min. 60		IF UNDER 24 HRS. Months 2 Days 24 Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Howard WATERS				14. MOTHER'S MAIDEN NAME Evelyn H. HOPE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) increased intracranial pressure 340.3 DUE TO and myocarditis with cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Meningo-encephalitis, organism unknown DUE TO meningo-encephalitis + myocarditis (c) meningo-encephalitis + myocarditis				INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (Nicholson) attended the deceased from July 24 19 60 to July 24 19 60 , that (I) (see last) saw the deceased alive on July 24 19 60 , and that death occurred at 3:10PM M, from the causes and on the date stated above.							
22a. SIGNATURE G. B. Avery				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-25-60	
22c. PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 7-27-60		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		23d. LOCATION (City, town, or county) (State) Greenville South Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Harkness Funeral Home, Mutual, Maryland				25a. REC'D BY REGISTRAR DATE JUL 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

115231

LETTER OF CREDIT

115231

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U. S. Bank of New York

NEW YORK

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TO HO, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8288

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08264

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md.		c. LENGTH OF STAY IN 1b 2½ years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4609 S. Chelsea La., Beth., Md.				d. STREET ADDRESS 4609 S. Chelsea La., Beth., Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Minnie A. Webster				4. DATE OF DEATH Month July Day 30 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1870		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josiah Clark				14. MOTHER'S MAIDEN NAME Mary Bartlett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Stewart H. Webster, 4609 S. Chelsea La.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) cerebral arteriosclerosis DUE TO (c) generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/16 19 60 to 7/30 19 60 , that (I) (we) last saw the deceased alive on 7/28 19 60 , and that death occurred at 5:45 P M, from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. O'Connor				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/30/60	
22c. PHYSICIAN'S NAME (Type) THOMAS F. O'CONNOR, M.D.				22d. ADDRESS 4861 BATTERY LANE BETHESDA 14, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 5, 1960		23c. NAME OF CEMETERY OR CREMATORY Hillside Cem.,		23d. LOCATION (City, town, or county) (State) Holley, New York	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR Aug 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8130

CERTIFICATE OF DEATH

Reg. Dist. No.

08265

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARTLEA NURSING HOME</u>		d. STREET ADDRESS <u>14511 COLESVILLE RD.</u>	
3. NAME OF DECEASED (Type or print) <u>ALICE BERRY WHALING</u>		4. DATE OF DEATH <u>JULY 15TH 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 8TH 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE BERRY</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>VIRGINIA B. TONES</u> Address <u>6084 NEVADA AVENUE NW WASH. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Generalized Cardiovascular System</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 - Acute myocardial infarction</u> DUE TO <u>2 -</u> (c) <u>2 -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>March 1, 1958</u> to <u>July 15, 1960</u> that I last saw the deceased alive on <u>July 14, 1960</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.		ADDRESS (Street, city or town, state) <u>1919 SEMINARY RD. SILVER SPRING MD</u>	
PHYSICIAN'S NAME (Type) <u>JOHN S. ROGERS</u>		DATE SIGNED <u>July 15, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Lodge</u> ADDRESS <u>517 11th St. S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 19 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frazier</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8130

WILLIAM BOND

Age 61

Place of Birth

Married

Place of Death

Usual Residence

Place of Death

Usual Residence

Place of Death

Usual Residence

Place of Death

Usual Residence

Place of Death

Usual Residence

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Place of Death

08265

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax																																																											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda										c. LENGTH OF STAY IN 1b 246 days										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church										d. STREET ADDRESS 104 South Virginia Avenue										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
3. NAME OF DECEASED (Type or print) John Louis Whittaker										4. DATE OF DEATH Month July Day 7 Year 19 60																																																											
5. SEX Male										6. COLOR OR RACE White										7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH August 11, 1933										9. AGE (In years lost birthday) 26 yrs.										10. IF UNDER 1 YEAR Months Days Hours Min.										11. IF UNDER 24 HRS.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk										10b. KIND OF BUSINESS OR INDUSTRY U.S. Government										11. BIRTHPLACE (State or foreign country) Pennsylvania										12. CITIZEN OF WHAT COUNTRY? U.S.A.																																							
13. FATHER'S NAME Louis Moniz										14. MOTHER'S MAIDEN NAME Irene Whittaker																																																											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No										16. SOCIAL SECURITY NO. 016-24-8655										17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland																																																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Synovial Sarcoma - Right Hip with metastasis to lungs & bone DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH 2 years																																																											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																																											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)																																							
21. I certify that (I) (this hospital) attended the deceased from November 4, 1959 to July 7, 1960 , that (I) (we) last saw the deceased alive on July 7, 1960 , and that death occurred at 5:24 PM , from the causes and on the date stated above.										22a. SIGNATURE George F. Miller, Jr. M.D.										22b. DATE SIGNED 7/8/60																																																	
22c. PHYSICIAN'S NAME (Type) George F. Miller, Jr., M.D.										22d. ADDRESS The Clinical Cenetr, National Institutes of Health, Bethesda 14, Md.																																																											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 7/11/60										23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.										23d. LOCATION (City, town, or county) (State) Silver Spring, Maryland																																							
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey										ADDRESS Bethesda, Maryland										25a. REC'D BY REGISTRAR JUL 12 '60										25b. REGISTRAR'S SIGNATURE Arthur S. House																																							

CERTIFICATE OF DEATH

City and State

County

101 North 7th Street, Room 101

The Clinical Center, Bethesda, Md.

John

March 11, 1933

Male

Investment

Louis Harris

The Clinical Center, Bethesda, Md.

31-32-1933 The Clinical Center, Bethesda, Md.

General purpose - light

with reference to Louis Harris

November 11, 1933 - July 7

July 7, 1933

George F. Miller

George F. Miller, Jr., M.D.

State of Maryland

Robert A. Humphrey, M.D.

1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
BM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08267

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Faithersburg</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Faithersburg (rural)</u>			
c. LENGTH OF STAY IN lb <u>life</u>				d. STREET ADDRESS <u>Elkision unity Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Elkision - unity Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Branda Lee Williams</u>				4. DATE OF DEATH <u>July 3 1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-18-1946</u>	
9. AGE (In years, last birthday) <u>15</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>			
11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>Herman Williams Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Selover Williams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Selover Williams - Sister</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X Asphyxia</u> DUE TO (b) <u>Upper Resp. Infection</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>7-3-60</u>			
				Address (Street, city, town, or county) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.,</u>		22d. LOCATION (City, town, or country) (State) <u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Burdick</u>				ADDRESS <u>Rockville, Md.</u>			
24a. REC'D BY REGISTRAR <u>Jul 6 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **8268**

8131

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b X Silver Spring (rural)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colesville - Fairland Rd.				d. STREET ADDRESS Colesville- Fairland Rd.			
3. NAME OF DECEASED (Type or print) ZILPHIA WINKIE				4. DATE OF DEATH Month July , Day 3 , Year 1960			
5. SEX female		6. COLOR OR RACE col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 2/1/1909			
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 51 Days 19		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ORANGE, VIRGINIA			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Robert Winkie			
14. MOTHER'S MAIDEN NAME Mary Synder				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT Police Record					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hernation of brain stem</p> <p>983X DUE TO Cerebral edema</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Subdural Hemorrhage</p> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH hrs. hrs. hrs. </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported beaten by common law husband					
20c. TIME OF INJURY Month, Day, Year ? a. m. 7/3/60 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home			
20f. (City or town) Silver Spring		(County) Montg. (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 7/4/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/6/60		22c. NAME OF CEMETERY OR CREMATORY Taft Williams Funeral Home., Washington, D. C.			
22d. LOCATION (City, town, or country) Rockville, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>				24a. REC'D BY REGISTRAR DATE JUL 11 '60			
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08269

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 11229 Ashley Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alan Middle Edward Last WITHAM				4. DATE OF DEATH Month July Day 20 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-8-57	
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Washington	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John M. WITHAM				14. MOTHER'S MAIDEN NAME Helen M. PASCOE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease - ventricular septal defect with moderate pulmonary hypertension (post operative status) DUE TO hypertension (post operative status) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
21. I certify that (I) (this hospital) attended the deceased from July 13 9:50PM to July 20 , 19 60 , that (I) (we) last saw the deceased alive on July 20 , 19 60 , and that death occurred at M , from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
22a. SIGNATURE J. E. MC CLENATHAN				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-21-60	
22c. PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-22-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				25a. REC'D BY REGISTRAR 25 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

STATE OF TEXAS
COUNTY OF DALLAS

(M)

U. S. Naval Hospital, Houston, Texas
I, J. B. Stewart, Clerk of the Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Court.

(1)

John K. Wright
Houston, Texas
Witness my hand and seal of office this 1st day of July, 1964.

J. B. Stewart, Clerk of the Court
U. S. Naval Hospital, Houston, Texas
1-21-64

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any way is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08270

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>montg</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
c. LENGTH OF STAY IN 1b <i>14 yrs</i>				d. STREET ADDRESS <i>10238 Capitol View Ave</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>10238 Capitol View Ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>James Earl Witherite</i>				4. DATE OF DEATH <i>July 12 1960</i>			
5. SEX <i>male</i> COLOR OR RACE <i>white</i>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
6. DATE OF BIRTH <i>8-21-1899</i>				9. AGE (In years, last birthday) <i>60</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PBX telephone repairman</i>				11. BIRTHPLACE (State or foreign country) <i>va</i>			
10b. KIND OF BUSINESS OR INDUSTRY <i>C&P Telephone Co.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Adam Witherite</i>				14. MOTHER'S MAIDEN NAME <i>Minnie McCarthy</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES WW #1</i>				16. SOCIAL SECURITY NO. <i>577-01-3327</i>			
17. INFORMANT <i>Pearl Witherite (wife)</i>				Address <i>Item 2</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>420.1</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Brockett</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. BROCKETT</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <i>7-12-60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>July 14, 1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATL. CEMETERY</i>		22d. LOCATION (City, town, or country) (State) <i>ARLINGTON, VIRGINIA</i>	
23. FUNERAL DIRECTOR <i>WARNER E. PUMPHREY, INC., SILVER SPRING, MD</i> <i>Raymond A. Ziska</i>				24a. REC'D BY REGISTRAR DATE <i>JUL 18 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinas</i>	

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8291

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>3 yr 7 mo</u>		d. STREET ADDRESS <u>13 Pooks Hill Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 Pooks Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edythe</u> Middle <u>G</u> Last <u>Zartman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 3, 1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rolandus Wenger</u>		14. MOTHER'S MAIDEN NAME <u>Ella E. Weaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-50-7414</u>	
17. INFORMANT <u>S.F. Zartman</u>		Address <u>3 Pooks Hill Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of pancreas</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/30, 1950</u> , to <u>present</u> , that I last saw the deceased alive on <u>7/24, 1960</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhau</u> M.D.		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave</u> DATE SIGNED <u>7/25/60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU</u>		<u>Cherry Chase 15 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>	22b. DATE THEREOF <u>7/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Brickerville, PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8292

CERTIFICATE OF DEATH

Reg. Dist. No. 08272

1. PLACE OF DEATH a. COUNTY Marilea Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville Md.		c. LENGTH OF STAY IN 1b 8 years ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilea Rest Home		d. STREET ADDRESS 7217 Forest Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret Zervakos		4. DATE OF DEATH Month July Day 21 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Athens Greece		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Nikita Stratigopoulos		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Straty Zervakos		Address Kent Village Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 40 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 8, 1957 to July 21, 1960 , that I last saw the deceased alive on July 21, 1960 , and that death occurred at 12:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John C Rogers M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 1719 Lemmonville Rd. Silver Springs, Maryland. 7-31-68	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/60	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn New York	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE JUL 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

